



Provider must call BCBSTX at 800-528-7264 to verify benefits. To expedite the processing of your request, please complete all sections of the form. For Outpatient Place of Service - Please fax to BCBSTX at 877-361-7646.

Request Submission Date: \_\_\_\_\_ Requested Testing Start Date: \_\_\_\_\_

<b>Patient and Subscriber Information</b>	
Patient Name _____	Date of Birth _____
Subscriber Name _____	Subscriber ID # _____ Group # _____

<b>Testing Provider Information</b>	<input type="checkbox"/> Medical Practitioner <input type="checkbox"/> BH Practitioner	<b>Place of Service</b> <input type="checkbox"/> Outpatient
Name _____	Licensure _____ NPI# _____	
Address _____	City _____ State _____ Zip _____	
Email Address _____	Phone # _____ Fax # _____	
If requesting neuropsychological testing, are you a board certified neuro-psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Referral Information</b>	Who referred the patient for testing? Name _____
Relationship to patient (i.e. PhD, PCP, Therapist, Medical Director, Parent, Psychiatrist, Teacher, School, etc.) _____	

<b>Assessment History</b>
Have you met with the patient to complete a diagnostic evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a diagnostic evaluation been completed by another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, the diagnostic eval was completed by? Name _____ Date _____ License Type: _____
Has the patient had previous psychological testing? <input type="checkbox"/> Yes, when? _____ <input type="checkbox"/> No <input type="checkbox"/> Not sure
Focus of Previous Testing: _____

<b>Current or Provisional Diagnosis</b>
<b>Current DX — Please include all DSM 5 and/or medical diagnoses that apply.</b>
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____

What clinical/referral question(s) need to be answered by testing that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the current symptoms and/or functional impairments related to the testing question(s)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





Patient Name \_\_\_\_\_

**Requested Testing**

Please include ALL tests that will be administered. If a test has multiple versions (i.e. parent, teacher, self-report), please indicate specifically which will be administered. If using selected subtests from a larger test please indicate which subtests will be administered.

CPT Testing Code Requested:	Total Hrs Requested per CPT Code	Specify names of test attributed to this CPT Code:
1 <input data-bbox="142 541 300 630" type="text"/>	<input data-bbox="373 541 531 630" type="text"/>	   
2 <input data-bbox="142 709 300 798" type="text"/>	<input data-bbox="373 709 531 798" type="text"/>	   
3 <input data-bbox="142 877 300 966" type="text"/>	<input data-bbox="373 877 531 966" type="text"/>	   
4 <input data-bbox="142 1045 300 1134" type="text"/>	<input data-bbox="373 1045 531 1134" type="text"/>	   
5 <input data-bbox="142 1213 300 1302" type="text"/>	<input data-bbox="373 1213 531 1302" type="text"/>	   

Total Hours for testing requested:

**Other Comments**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature confirms that I am providing the requested services:

Signature \_\_\_\_\_ Date \_\_\_\_\_

