



PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

RESET

IDENTIFYING INFORMATION	
Dates of Service Requested: (Start) _____ (End) _____	
First Name: _____	Last Name: _____ MI: _____
Date of Birth (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Other: _____	
Policy Number: _____	
Health Plan: _____	
Date Form Submitted: _____ Preferred Language (if other than English): _____	
Servicing Clinician: _____	Facility: _____
Phone Number: _____ TIN/NPI#: _____	
Name and Role of Referring Individual: _____ <input type="checkbox"/> Self Referred	
Contact Person: _____ Best Time to Contact: _____	
Phone Number: _____ Fax: _____	
Email: _____	
Site Address: _____	
Requesting Clinician/Facility (only if different than service provider):	
Phone Number: _____ TIN/NPI#: _____	
Contact Person: _____ Best Time to Contact: _____	
Phone Number: _____ Fax: _____	
Email: _____	
RELEVANT DIAGNOSTIC DATA	
Primary possible diagnosis which is the focus of this assessment: _____	
Possible comorbid or alternative diagnoses: _____ <input type="checkbox"/> None	
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed: _____ <input type="checkbox"/> None	
Relevant results of imaging or other diagnostic procedures (provide dates for each): _____ <input type="checkbox"/> None	
ASSESSMENT PLAN AND HISTORY	
Psychological and Neuropsychological Test Evaluation Services	Psychological and Neuropsychological Test Administration and Scoring
<i>Please enter number of units requested</i>	
Psychological Testing Evaluation Services, 1 st hour 96130=	Test Admin by Professional, first 30 minutes 96136=
Additional hour (List Separately) 96131=	Additional 30 minutes (List separately) 96137=
Neuropsychological Testing Evaluation Service, 1 st hour 96132=	Test Admin by Technician, first 30 minutes 96138=
Additional hour (List Separately) 96133=	Additional 30 minutes (List separately) 96139=
Automated Testing and Result 96146=	Neurobehavioral status exam, 1 st hour 96116=
	Additional hour (List separately) 96121=

List Likely Tests:	
What suspected or confirmed factors suggested that assessment may require more time relative to test standardization samples?	
<input type="checkbox"/> Depressed mood <input type="checkbox"/> Low frustration tolerance <input type="checkbox"/> Vegetative symptom <input type="checkbox"/> Grapho-motor deficits <input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Physical symptoms or conditions (such as): <input type="checkbox"/> Suspected processing speed deficits <input type="checkbox"/> Performance Anxiety <input type="checkbox"/> Receptive communication difficulties
Why is this assessment necessary at this time?	
<input type="checkbox"/> Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities. <input type="checkbox"/> Results will help formulate or reformulate a comprehensive and optimally effective treatment plan. <input type="checkbox"/> Assessment of treatment response or progress when the therapeutic response is significantly different than expected. <input type="checkbox"/> Evaluation of a member's functional capability to participate in health care treatment <input type="checkbox"/> Determine the clinical and functional significance of brain abnormality. <input type="checkbox"/> Dangerousness assessment <input type="checkbox"/> Assess mood and personality characteristics impact experience or perception of pain. <input type="checkbox"/> Other (describe):	
Has a standard clinical evaluation been completed in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, when and by whom:	
If no, explain why a standard clinical evaluation cannot answer the assessment questions:	
Date of last known assessment of this type: <input type="checkbox"/> No prior testing	
If testing in past year, why are these services necessary now?	
<input type="checkbox"/> Unexpected change in symptoms <input type="checkbox"/> Evaluate response to treatment <input type="checkbox"/> Assess function	<input type="checkbox"/> Previous assessment is likely invalid <input type="checkbox"/> Other (please specify):
Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, learning disorders and/or guiding health care services? <input type="checkbox"/> Y <input type="checkbox"/> N	
Are the units requested for the primary purpose of determining special needs educational programs? <input type="checkbox"/> Y <input type="checkbox"/> N	
Are the units requested to answer questions of law under a court order? <input type="checkbox"/> Y <input type="checkbox"/> N	
Currently known symptoms and functional impairments of the patient that warrant this assessment:	
RELEVANT MENTAL HEALTH/SUD HISTORY	
Relevant Mental Health History: <input type="checkbox"/> None	
Is substance use disorder suspected? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many days of sobriety:
Are medication effects a likely and primary cause of the impairment being assessed? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? <input type="checkbox"/> Y <input type="checkbox"/> N	
If no, explain why testing is necessary:	

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- Aconclusive diagnosis was not determined by a standard examination
- And/or specific deficits related to or co-existing with ADHD need to be further evaluated
- Other (please specify):

Signature of requesting clinician:

Please submit form through NaviNet: [https://navinet.navimedix.com/sign-in?ReturnUrl=/](https://navinet.navimedix.com/sign-in?ReturnUrl/)

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