Aetna Better Health® of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

Neuropsychological Testing Prior Authorization Form

Fax to: **1-844-528-3453** Telephone: **1-866-329-4701**

A determination will be communicated to the requesting provider.
Incomplete requests will delay the prior authorization process.

TYPE OF REQUEST

☐ **URGENT:** When a 4-calendar day non-urgent prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or the delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested.

☐ **NON-URGENT:** For routine services and a response within 4 calendar days.

☐ **Court Ordered or CPS Request**

PATIENT INFORMATION

Patient Name: **Last** **First** **MI**				**Date of Birth:** / /
I.D. #:		**Gender:** ☐ Male ☐ Female		**EPSDT Special Service Request?**
Other Insurance? ☐ Yes ☐ No	**Name of Carrier:**	**Job Related?** ☐ Yes ☐ No	**MVA?** ☐ Yes ☐ No	**Is the member currently pregnant?** ☐ Yes ☐ No

FROM - REQUESTING PROVIDER

Requesting Provider (Please Print):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**Medicaid Provider #:**
Name of Clinical Contact Person: **Phone: ( ) -**	**Name of PCP:**		

WHERE WILL PATIENT RECEIVE SERVICES?			
Physician/Provider/Facility Requested:	**Address:**	**Telephone:** **( ) -**	**Fax:** **( ) -**
Where services will be rendered? (Provide name of facility, if other than provider office)			**Medicaid Provider #:**
Today's Date: / /		**Tentative Date of Service/Admission: / /**	
Were member school-based services interrupted? ☐ Yes ☐ No		**Start Date: / /** **End Date: / /**	

CLINICAL INFORMATION	
ICD-10 Codes: **1) 2) 3) 4)**	**ICD-10 Description:**
CPT/HCPCS Codes: **1) 2) 3) 4)**	**CPT/HCPCS Description:**
List number of days/visits/units, or if services are needed at discharge:	

EXAMPLE OF PLAN SPECIFIC INSTRUCTIONS: In order to meet evidence-based criteria, neuropsychological testing should only be requested for establishing a differential diagnosis that is crucial to initiating or modifying a treatment plan. Before requesting authorization for neuropsychological testing, you must complete a face-to-face evaluation of sufficient detail to complete the questions below.

CLINICAL ASSESSMENT
1. Clinical Interview Data (Include relevant psycho/social/behavioral history, current symptoms, impairments in functioning, mental status exam, etc.)
2. Purpose of Testing (Include referral question, differential diagnostic issues to be addressed, and how treatment will be affected by results of testing)
3. Prior Medical and Mental Health Test Results (Include diagnoses, dates of prior testing and the names of completed tests)
4. Which of the following diagnostic/assessment techniques have been completed?

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☐ Diagnostic Interview
Date completed: _____

☐ Mental Status Exam
Date completed: _____

☐ Clinical Review
Date completed: _____

☐ Comprehensive Psycho-social-behavioral History
Date completed: _____

☐ Brief Rating Scale (i.e. BDI)
Date completed: _____

5. PLEASE SPECIFY IF ADMINISTERING STANDARD BATTERY OR SELECTED SUBTESTS ONLY

Clinical Questions		Specific Test(s) Requested	Hours
a)	Intellectual		
b)	Language		
c)	Attention/Concentration		
d)	Memory		
e)	Executive Function		
f)	Visual/Spatial		
g)	Motor/Sensory		
h)	Affective/Mood		
		Total Time Requested	

6. SUBSTANCE USE HISTORY

Substance	Date of Last Use	Frequency	Amount Used

CPT Code(s) Requested

CPT Code	Code Description	Hours

Total Time Requested	

I hereby certify that I am the practitioner who will be performing the testing and the above statements are true and correct:

Provider Name: (Please Print)	**Provider Signature:**	**Date:**
Provider NPI:	**Telephone Number:** **( ) -**	**Fax Number:** **( ) -**
Address: (Street, City, State, and Zip Code)		

Practitioner Signature: _____ **Date:** _____