SUBMIT TO
Utilization Management Department
PHONE 1-866-595-8133 | FAX 1-888-725-0101

louisiana healthcare connections™

INPATIENT AND OUTPATIENT NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING

Please print clearly – incomplete or illegible forms will delay processing.

Date_____

PATIENT INFORMATION

Name _____

Date of Birth_____

Member ID#_____

Social Security# _____

PROVIDER INFORMATION

Provider Name _____

Group Name_____

Phone_____

Fax _____

MEDICAL INFORMATION

History of medical condition, trauma or substance use disorder that may have neuropsychological consequences to the patient:

Patient's cognitive symptoms/issues:

Patient's psychiatric symptoms/issues:

History of previous treatments for the above symptoms:

Will this testing all or in part be used for educational/vocational remediation? ☐ Yes ☐ No

If yes, please explain:

How will understanding the neuropsychological status of this patient affect the treatment plan?

What are the patient's diagnostic rule outs/referral questions?

PLEASE CHECK THE APPROPRIATE NEUROPSYCHOLOGICAL TESTING CODE (SELECT ONLY ONE)

Test Planned	Date Requested	Time Requested
☐ 96116		
☐ 96118		
☐ 96119		
☐ 96120		

PLEASE CHECK THE APPROPRIATE PSYCHOLOGICAL TESTING CODE (SELECT ONLY ONE)

Test Planned	Date Requested	Time Requested
☐ 96101		
☐ 96102		
☐ 96103		
☐ 96105		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

Clinician Name	Clinician Signature	Date

Date Received	Date Processed	Referral Source

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