



Provider must call BCBSNM at 888-898-0070 to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSNM at 877-361-7659.

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

<b>Patient and Subscriber Information</b>	
Patient Name _____	Patient Date of Birth _____
Subscriber Name _____	Subscriber ID _____ Group _____
<b>Testing Provider Information</b>	<input type="checkbox"/> Medical <input type="checkbox"/> BH    Type of Licensure _____ Testing Location _____ (Example: Psychologist, Psychiatrist)
Name _____	NPI _____
Address _____	City _____ State _____ Zip _____
Email Address _____	Phone _____ Fax _____
Are you a board certified neuropsychologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a clinical neuropsychologist? <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 If yes, date _____	
Has a diagnostic evaluation been completed by another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who completed the diagnostic evaluation? 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 _____	
Current DX — Please include all DSM 5 and/or medical diagnoses that apply.	
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.

Will a technician be providing any services for this evaluation?  Yes  No

If yes, please specify the applicable technician CPT codes.

CPT Testing Code Requested	Total Units Requested per CPT Code	Specify names of tests or type of service attributed to this CPT code
1		
2		
3		
4		
5		
6		
7		
8		

Total Units Requested \_\_\_\_\_

**Other Comments**

Empty box for other comments.

My signature confirms that I am providing the requested services:

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

