BlueCross BlueShield of New Mexico

Psychological or Neuropsychological TESTING REQUEST FORM

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.
For Outpatient Place of Service - Please fax to BCBSNM at 877-361-7659.

Request Submission Date: _____ **Requested Testing Start Date:** _____

Patient and Subscriber Information

Patient Name_____ Date of Birth_____

Subscriber Name_____ Subscriber ID #_____Group #_____

Testing Provider Information

☐ Medical Practitioner ☐ BH Practitioner **Place of Service** ☐ Outpatient

Name _____ Licensure_____NPI#_____

Address_____ City_____State_____ Zip_____

Email Address_____ Phone #_____Fax #_____

If requesting neuropsychological testing, are you a board certified neuro-psychologist? ☐ Yes ☐ No

Referral Information

Who referred the patient for testing? Name _____

Relationship to patient (i.e. PhD, PCP, Therapist, Medical Director, Parent, Psychiatrist, Teacher, School, etc.) _____

Assessment History

Have you met with the patient to complete a diagnostic evaluation? ☐ Yes ☐ No

Has a diagnostic evaluation been completed by another provider? ☐ Yes ☐ No

If yes, the diagnostic eval was completed by? Name _____Date_____License Type:_____

Has the patient had previous psychological testing? ☐ Yes, when?_____ ☐ No ☐ Not sure

Focus of Previous Testing: _____

Current or Provisional Diagnosis

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: _____ DX Name: _____ Specifier: _____

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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)?

P S Y T

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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		
2		
3		
4		
5		

Total Hours for testing requested:

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____

P S Y T

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