Keystone First
VIP Choice

Neuropsychological Testing Request ☐

Psychological Testing Request ☐

Please check one of the above. When complete, fax to 1-855-396-5740.

Please type or print clearly. Incomplete and illegible forms will delay processing.

1. Member information

Member name:	Eligibility ID #:	SSN:	DOB:
Member address:	City, state, ZIP code:	Phone:	
Who referred member for treatment?			

2. Treating provider information

Name (with credentials):	NPI #:	Phone:
Address:	City, state, ZIP code:	Fax:
Group name or ID number:	Contact name:	Treating provider signature:

3. Testing requested

☐ **Neuropsychological:** Insert service codes being requested:

☐ **Psychological:** Insert service codes being requested:

Referral reason and functional impairment:

How will the anticipated results affect the member's treatment plan?

4. DSM-5 diagnosis

List all mental health, substance use, and medical diagnoses:

5. Current symptoms prompting request for testing

☐ Anxiety
☐ Psychosis or hallucinations
☐ Mood instability
☐ Bizarre behavior
☐ Inattention
☐ Hyperactivity
☐ Withdrawal or social isolation
☐ Unprovoked agitation or aggression
☐ Self-injurious behaviors
☐ Eating disorder symptoms
☐ Behaviors impacting activities of daily living (ADLs)
☐ Depression
☐ Poor academic or employment performance
☐ Other: ____________________________

6. Current medications

List with dosages or attach sheet:

7. Assessments to date

☐ No assessment procedures performed to date
☐ Direct observation
☐ Assessment by mental health professionals
☐ Consultation with others
☐ Structured interview
☐ Interview with family or guardians
☐ Medical evaluation
☐ Review of records of previous treatment
☐ Clinical interview with patient
☐ Brief inventories or rating scales
☐ Consultation with patient's provider
☐ Other (please list): ____________________________________

Original March 2016

Neuropsychological/Psychological Testing Request

Please answer the following. Attach additional pages and records if necessary.

Patient medical and psychiatric history: ______________________________

Family medical and psychiatric history: ______________________________

Describe any neurological events and/or neuro-developmental concerns: ______________________________

History of psychological testing and results or findings: ______________________________

8. Description of testing request		
Test to be administered	**Time required** (administration of test, scoring, interpretation, and report preparation)	**Comments**

Additional information

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