Prior Authorization Request Form

Neuropsychological Testing Use only for Commercial LOB

Standard fax number: (844) 742-1155	**Urgent fax number: (844) 729-1416**

Use AuthAccel, Blue Shield of California's online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (**blueshieldca.com/provider**) and click the *Authorizations* tab to get started.

Blue Shield has a five business day turnaround time on all standard prior authorization requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Important for urgent requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to severe pain, potential loss of life, limb, or major bodily function, and a delay in decision-making might seriously jeopardize the life or health of the enrollee. If there is no MD signature present, the request will be processed as a standard request.

MD signature REQUIRED for urgent requests only:

Type of request: ☐ New standard request ☐ Retro request ☐ Urgent request

If you are submitting a modification or extension, check one, and complete the details below: ☐ Modification request ☐ Extension request

Previous authorization number:	Current last authorized day:	New authorization end date:

Provider justification for modification or extension:

Patient information

First name:	Last name:	
Date of birth (DOB):	Blue Shield subscriber ID number:	
Street address:	City:	
Home phone:	State:	ZIP code:
Cell phone:	Primary: ☐ Home ☐ Cell	
Require interpreter: ☐ Yes ☐ No ☐ American Sign Language		

Requesting provider

Provider first name:	Provider last name:	
Group name:	Group tax ID:	
Group NPI:	Specialist type:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	

Servicing/rendering provider	**If same as requesting provider, check ☐**	
Provider first name:	Provider last name:	
Group name:	Group tax ID:	
Group NPI:	Specialist type:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	

Place of service (check one box only):

☐ Office ☐ Other (please specify) _____

CPT/HCPC code(s):

Procedure code	96116	96121	96132	96133	96136
Number of units					

Procedure code	96137	96138	96139	96146
Number of units				

Diagnosis: ICD-10 code(s):

*****See patient clinical information box below for required documentation*****

Requested start date of authorization:

Contact name: Contact fax number:

Contact phone: Is the voicemail confidential: ☐ Yes ☐ No

Patient clinical information

Please provide the following documentation:

History and physical and/or consultation notes including:

- ☐ List of tests being administered
- ☐ Complete neurological examination
- ☐ Mental status exam **(including current symptoms and functional impairments)**
- ☐ Current diagnoses or comorbidities including DSM-V diagnosis(es) if available
- ☐ Purpose of testing (outstanding issues related to differential diagnosis or rule-out diagnoses to be evaluated)

Please respond to the following:

- Is the testing request for educational, vocational, or other non-clinical purposes?
  ☐ No ☐ Yes
- Has the member had previous neuropsychological testing? If yes, provide details including dates of tests and the need for additional or repeat testing.
  ☐ No ☐ Yes Details: _____
- Have routine screening tools been used? If yes, submit details including dates of screening.
  ☐ No ☐ Yes Details: _____
- Has the member used any substances in the past 30 days? If yes, submit details.
  ☐ No ☐ Yes Details: _____
- Does the member experience cognitive impairments that would impact the testing process or outcomes? If yes, submit details.
  ☐ No ☐ Yes Details: _____
- Has the member previously been diagnosed with a brain disorder? If yes, provide details.
  ☐ No ☐ Yes Details: _____