



PRE-AUTHORIZATION REQUEST FOR PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING

Instructions: In order to facilitate rapid processing of your request, please:

- Type or print legibly to prevent the return of forms for clarification.
- The authorization must be obtained PRIOR to actual testing. This service must be pre-certified.
- Identify self-report inventories, checklists, etc. to be completed by the Member, parent or clinician.
- When completed, fax this request to: 717/540-1146
- Any questions, call 1-866-755-7299 and ask to speak to a Gateway Health Plan® Care Manager

Date of Request: _____

MEMBER INFORMATION:

First and Last Name: _____ Date of Birth: _____

Gateway Health Plan® ID Number: _____ Social Security #: _____

Other Insurance: _____ County of Residence: _____

PROVIDER INFORMATION:

Agency Requesting Service: _____ Contact Person: _____

Address: _____ Phone Number: _____

Fax Number: _____

Date of testing (if scheduled): _____

CLINICAL INFORMATION:

Referral source: _____

Clinical symptoms & reason(s) for referral for testing:

Specific question(s) that testing is intended to answer (and why this cannot be answered through other means):



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Description of how the testing results will *direct treatment planning*. Include justifications as to why other interventions (e.g. psychiatric evaluation, outpatient therapy, second opinion, etc.) would not better accomplish the same results.

Treatment history, including service (e.g., outpatient, inpatient), Provider, and dates:

Prior testing/evaluations, including dates and results/findings:

If the Member has had testing done in the past, please explain the reason for retesting:



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Working diagnoses and rule outs:

Have medication side effects and substance use been ruled as the cause of cognitive impairment?

Yes No

Explain:

For neuropsychological testing requests, describe any neurological incidents/events and/or neurodevelopmental concerns.

Other information:
