GEHA

Neuropsychological Testing (NPT)

For services effective 1/1/2022

- **Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.**

For services received prior to 1/1/2022

- If the patient lives in Delaware, Florida, Louisiana, Maryland, North Carolina, Oklahoma, Texas, Virginia, Washington D.C., West Virginia, or Wisconsin, **do not complete form.** Contact UnitedHealthcare Choice Plus at 877.585.9643.
- Please complete this form if the member lives in a state not listed above.

If the testing, including time for interpretation and report, will take 8 hours or less, it does not need to be authorized.

Purpose of this form

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

How to complete the form

We recommend reviewing **GEHA's coverage for Neuropsychological Testing (NPT) before completing this form**. You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need assistance, please call 800.821.6136, ext. 3100.

After you have completed the form

Our reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health, or ability to regain maximum function. Post-service reviews are completed within 30 days.

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Neuropsychological Testing (NPT)

Today's date: _____

Member information

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

ID number: _____ Date of birth: _____

Member address: _____ City: _____ State: _____ Zip: _____

Authorization information

Has test been started? ☐ Yes ☐ No Date started: _____

Purpose of testing? _____

Provider information

Provider name: _____

Type of license: ☐ Nurse ☐ Psychologist ☐ Physician ☐ Professional Counselor ☐ Social Worker ☐ Other ☐ None

Degree: ☐ PHD ☐ PSYD ☐ EDD ☐ DO ☐ MSW ☐ MA/MS ☐ MD

Tax ID: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Requestor name: _____ Phone: _____ Ext: _____

Email address: _____

Was patient referred for testing? ☐ Yes ☐ No

Person/Agency making initial request?

- ☐ Psychiatrist
- ☐ Psychotherapist
- ☐ Testing psychologist
- ☐ Other psychologist
- ☐ Parent
- ☐ Court
- ☐ School staff (specify): _____
- ☐ PCP/Medical specialist: _____
- ☐ Other: _____

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Case information

Case Background: _____

_____

Medical/psychological evaluation and treatments

1. Has the initial psychologist or Behavioral Health Professional completed an initial diagnostic evaluation?
   - ☐ Yes If yes, date of evaluation? _____
   - ☐ No
2. Has the patient had an evaluation by a psychiatrist?
   - ☐ Yes If yes, date of evaluation? _____
   - ☐ No
3. Has the patient had previous psych testing?
   - ☐ Yes If yes, date? _____ Focus? _____
   - ☐ No
4. Has the member had any substance abuse in the last 30 days?
   - ☐ Yes If yes, explain: _____
   - ☐ No
5. Purpose of Testing? _____

What clinical question needs to be answered by testing? _____

_____

_____

Current ICD-10 codes Number(s)	Current or Provisional Diagnosis	Description

Rule-Out ICD Diagnostic Code Number(s): _____

What are the current symptoms and/or functional impairments related to testing questions? ____

_____

_____

How would the results of testing affect the treatment plan? _____

_____

Number of hours of testing requested: _____

☐ Psychological testing ☐ Neuropsychological testing

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CPT codes	Number of units	CPT codes	Number of units
☐ 96130 (only 1 hour allowed)		☐ 96137 – additional 30 min	
☐ 96131 – additional hours		☐ 96138 (only one unit of 30 min)	
☐ 96132 (only 1 hour allowed)		☐ 96139 – additional 30 min	
☐ 96133 – additional hours		☐ 96146 – only 1 unit allowed	
☐ 96136 (only one unit of 30 min)		☐ Other	

Has testing already been completed

☐ Yes If yes, when? _____

☐ No

Anticipated date(s) of service: _____

Preliminary list of tests you will attempt to complete? _____

_____

_____

_____

The clinical information below is mandatory to evaluate medical necessity and should be submitted along with this form to GEHA:

- ☐ Patient history/evaluation (including tried and failed treatments).
- ☐ Current presentation of symptoms.
- ☐ Treatment plan.

Please fax completed form and supporting documents to GEHA's Care Management Department at 816.257.3255 or 816.257.3515.*

Or mail documents to:

GEHA
Care Management Department
P.O. Box 21542
Eagan, MN 55121

Questions: Call Care Management at 800.821.6136, Ext 3100.

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity, and patient eligibility on the date that the service is provided, or the supply delivered.