BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

BERLIN
445 INDUSTRIAL LANE
BERLIN, VERMONT 05602

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
800 255 4550

Psychological/Neuropsychological Testing Clinical Information Worksheet

Prior approval is required for psychological and neuropsychological testing. Completion of this worksheet is not mandatory, however this clinical information aides BCBSVT staff in completing these requests.

Date of Request:	Requested Date(s) of Service:
Patient Name:	Patient DOB:
Provider Administering Tests:	Provider's Credentials:

Person or Agency Making the Initial Recommendation for Testing:

	Psychiatrist		Psychotherapist		Testing Psychologist
	Other Psychologist		Parent		Court/Probation
	Teacher/School Staff *(specify)*:				
	PCP / Medical Specialist *(specify)*:				
	Other:				

1. Are there any known contributing medical issues , including any known pregnancy/birth complications, brain injury, head trauma, lead poisoning etc.?

2. What are the current symptoms and/or functional impairments the member is experiencing?

3. Has the member has been referred for testing based upon a clinical evaluation from a Medical Professional? □ Yes □ No
   **If yes, please attach notes documenting this*

4. Please list the specific question(s) to be addressed by testing:

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5. How will results of testing facilitate treatment goals and/or provide information beyond that currently available? *Please be as specific as possible.*

6. If current testing is ADHD-related, indicate most recent results of Connors' or similar ADHD rating scales:
   □ Testing is not ADHD-related □ Rating scales were positive □ Negative
   □ Rating scales were inconclusive □ Rating scales were not administered

7. Have medication effects been ruled out as a cause for symptoms in question? □ Yes □ No*
   **If No, describe rationale for testing despite this information.*

8. Does the member have active alcohol or substance use that would be expected to affect the validity of testing? □ Yes* □ No
   **If Yes, describe rationale for testing despite this information.*

****Please complete the following page*****

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Requested Testing (if unknown by ordering provider, please leave blank):

Total number of hours requested: _____
Is testing primarily neuropsychological? □ Yes □ No

Names and Type of Test: *(Please print clearly and be precise when indicating the names or acronyms of the tests)*	**Time requested per test** *(include administration, scoring, interpretation and reporting)*:

**Please attach additional sheet if needed.*

CPT® Code Requested	**Number of Units for Each Code**

Requesting Provider Signature: _____ Date: _____