BlueCross BlueShield of Illinois

Psychological or Neuropsychological
TESTING REQUEST FORM

Provider must call BCBSIL at **800-851-7498** to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSIL at **877-361-7656.**

Request Submission Date _____ Requested Testing Start Date _____

Patient and Subscriber Information

Patient name _____ **Patient date of birth** _____

Subscriber name _____ **Subscriber ID** _____ **Group** _____

Rendering Provider Information

Type of licensure _____
(Example: Psychologist, Psychiatrist, MD, PhD, PsyD)

Billing name _____ **NPI** _____ **Group name** _____

Rendering name _____ **NPI** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Email address _____ **Phone** _____ **Fax** _____

Are you a clinical neuropsychologist? ☐ Yes ☐ No

Office contact name _____ **Phone** _____

Referral Information

Who referred the patient for testing? Name _____

Relationship to patient (i.e. self, PCP, Therapist, Parent, Psychiatrist, Teacher, School, etc.) _____

Assessment History

Have you met with the patient to complete a diagnostic evaluation? ☐ Yes ☐ No **If yes, date** _____

Has a diagnostic evaluation been completed by another provider? ☐ Yes ☐ No

If yes, who completed the diagnostic evaluation? Name _____ Date _____ License Type _____

Has the patient had previous psychological/neuropsychological testing? ☐ Yes, when? _____ ☐ No ☐ Not sure

Focus of previous testing _____

Current DX — Please include all DSM 5, ICD 10 and/or medical diagnoses that apply.

Code _____ DX Name _____ Specifier _____
Code _____ DX Name _____ Specifier _____
Code _____ DX Name _____ Specifier _____
Code _____ DX Name _____ Specifier _____

What clinical/referral question(s) need to be answered by testing that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?

What are the current symptoms and/or functional impairments related to the testing question(s)?

PSYT

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Patient Name _____

Requested Testing

Please include ALL tests that will be administered. If a test has multiple versions (i.e. parent, teacher, self-report), please indicate specifically which will be administered. If using selected subtests from a larger test, please indicate which subtests will be administered.

Will a technician be providing any services for this evaluation? ☐ Yes ☐ No

Technician name _____ **Credentials** _____

Please list the applicable technician CPT codes below.

CPT Testing Code Requested	Total Units Requested per CPT Code	Specify names of tests or type of service attributed to this CPT code
1		
2		
3		
4		
5		
6		
7		
8		

Total Units Requested _____

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____

Print name _____

PSYT