BlueCross BlueShield of Montana

Psychological or Neuropsychological
TESTING REQUEST FORM

Provider must call BCBSMT at **855-313-8909** to verify benefits. To expedite the processing of your request, please complete all sections of the form.
For Outpatient Place of Service - Please fax to BCBSMT at **855-649-9681.**

Request Submission Date _____ Requested Testing Start Date _____

Patient and Subscriber Information

Patient Name _____ **Patient Date of Birth** _____

Subscriber Name _____ **Subscriber ID** _____ **Group** _____

Testing Provider Information

☐ **Medical Practitioner** ☐ **BH Practitioner** **Place of Service** ☐ Outpatient

Name _____ **Licensure** _____ **NPI** _____

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

Email Address _____ **Phone** _____ **Fax** _____

If requesting neuropsychological testing, are you a board certified neuro-psychologist? ☐ Yes ☐ No

Referral Information

Who referred the patient for testing? Name _____

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

Assessment History

Have you met with the patient to complete a diagnostic evaluation? ☐ Yes ☐ No

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 testing? ☐ Yes, when?_____ ☐ No ☐ Not sure

Focus of Previous Testing _____

Current or Provisional Diagnosis

Current DX — Please include all DSM 5 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)?

P S Y T

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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.

CPT Testing Code Requested	Total Units Requested per CPT Code	Specify names of test attributed to this CPT Code
1		
2		
3		
4		
5		
6		
7		
8		

Total Hours for
Testing Requested _____

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____

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PSYT