Psychological and Neuropsychological Notification Form

New Hampshire

WellSense HEALTH PLAN

Fax: 857-264-2670

Provider Portal: HealthTrio connect - Sign In

Identifying information		
Date of service requested: Start:	End:	
First name:	Last name:	MI:
Date of birth (mm/dd/yyyy):	Sex: ☐Male ☐Female Other: _____	
Policy number:		
Health plan:	Health plan fax#:	
Date form submitted:		
Servicing clinician:	Facility:	
Address:		
Phone number:	NPI:	TIN:
Name and role of referring individual:	☐ Self referred	
Contact person:	Best time to contact:	
Phone number:	Fax:	
Email:		
Requesting clinician/facility (only if different than service provider):		
Address:		
Phone number:	NPI:	TIN:
Contact person:	Best time to contact:	
Phone number:	Fax:	
Email:		

CLEAR FORM

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Relevant diagnostic data

Primary possible diagnosis which is the focus of this assessment?

Possible comorbid or alternative diagnoses:

☐None

List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:

☐None

Relevant results of imaging or other diagnostic procedures (provide dates for each)

☐None

CPT codes requested

Psychological testing evaluation (per 60 minutes)	Neuropsychological testing evaluation (per 60 minutes)	Neurobehavioral status evaluation
96130=	96132=	96116=
96131=	96133=	96121=
Test administration (per 30 minutes)	Test administration (per 30 minutes)	
96136=	96136=	
96137=	96137=	
96138=	96138=	
96139=	96139=	

List likely tests:

What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples? **(continued on next page)**

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☐Depressed mood	☐Physical symptoms or conditions such as:
☐Low frustration tolerance	☐Performance anxiety
☐Vegetative symptom	☐Receptive communication difficulties
☐Grapho-motor deficits	☐Other:
☐Suspected processing speed deficits	

Why is this assessment necessary at this time?

☐ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.

☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.

☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.

☐ Evaluation of a member's functional capability to participate in health care treatment.

☐ Determine the clinical and functional significance of brain abnormality.

☐ Dangerousness assessment.

☐ Assess mood and personality characteristics impact experience or perception of pain.

☐ Other (describe): _____

Has a standard clinical evaluation been completed in the past 12 months? ☐Y ☐N

If yes, when and by whom?

Explain why a standard clinical evaluation was not or would not be able to answer the assessment questions.

Date of last known assessment of this type: ☐ None

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If testing in past year, why are these services necessary now?

☐Unexpected change in symptoms

☐Evaluate response to treatment

☐Assess function

☐Previous assessment is likely invalid

☐Other (specify): _____

Are the units requested for the primary purpose of differentiating between medical, psychiatric conditions, and/or learning disorders and/or guiding health care services? ☐ Y ☐N

Are the units requested for the primary purpose of determining special needs educational programs? ☐Y ☐N

Are the units requested to answer questions of law under a court order? ☐Y ☐N

What are the patient's currently known symptoms and functional impairments that warrant this assessment? If neuropsych assessment is requested, clearly describe specific cognitive impairments and suspected brain insult.

_____

_____

_____

Relevant mental health/SUD history

Relevant mental health history	☐None
Is substance use/dependence suspected? ☐ Y ☐ N	If yes, how many days of sobriety?

Are medication effects a likely and primary cause of the impairment being assessed ☐ Y ☐ N

If no, explain why testing is necessary. _____

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan

☐ A conclusive diagnosis was not determined by a standard examination and/or

☐ Specific deficits related to or co-existing with ADHD need to be further evaluated

Signature of requesting clinician: _____