Magnolia Health Plan Cenpatico Improving Lives

INPATIENT NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST

Patient's Name: ____________________ **SSN#:** _____-_____-_____ **DOB:** _____/_____/_____

Provider's Name: ____________________ **Group Name:** ____________________________

Provider's Phone Number: (_____) _______-______ **Fax:** (_____) _______-______

History of medical condition, trauma, or substance use that may have neuropsychological consequences to the patient:____

____

Patient's cognitive symptoms/issues:____

____

____

Patient's psychiatric symptoms/issues:____

____

____

History of previous treatments for the above symptoms:_________________________

____

Will this testing all or in part be used for educational/vocational remediation? ☐ Yes ☐ No
If yes, please explain:____

How will understanding the neuropsychological status of this patient affect the treatment plan?____

What are the patient's diagnostic rule outs/referral questions?___________________

Test Planned:	Date Requested:	Time Requested:
1.		
2.		
3.		
4.		
5.		
6.		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

______________________ ______________________ __________
Clinician Name Clinician Signature Date

SUBMIT TO:
Utilization Management Department
504 Lavaca, Suite 850
Austin, TX 78701
(866) 912-6285
FAX (866) 694-3649

Date Received:__________ Date Processed:__________ Referral Source:____________________