



Provider must call BCBSNM at 888-898-0070 to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSNM at 877-361-7659.

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
Billing name NPI Group name
Rendering name NPI
Address City State Zip
Email address Phone Fax
Are you a clinical neuropsychologist?
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?
Has a diagnostic evaluation been completed by another provider?
If yes, who completed the diagnostic evaluation?
Has the patient had previous psychological/neuropsychological testing?
Focus of previous testing
Current DX - Please include all DSM 5, ICD 10 and/or medical diagnoses that apply.

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)?





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**

Empty box for other comments.

My signature confirms that I am providing the requested services:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

