TRICARE REQUEST FOR PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING

Fax Number: 1-866-811-4422

Beneficiary Name: ______________________ DOB: __________ Sponsor's ID: __________

Referral Source: ________________________ Specialty: ________________________

Type of ongoing care: Psychological Psychiatric Neurological Other: ________________

Current level of care: Inpatient Outpatient Partial Hospitalization Program (PHP testing is included in per diem payment.)

Referral question to be answered:

What efforts have been made to answer this referral question?

How will testing results contribute to treatment planning?

Has previous testing occurred? Yes No If yes, please indicate dates, type of testing, and name of provider.

Date of last medical exam:

Provisional Diagnosis(es):

Axis I: Axis II: Axis III:

Current Symptomatology (frequency, intensity, and duration):

Proposed Testing:

Name of Test: Requested CPT Code:

CPT 96101 – testing by psychologist, 96102 – testing by technician, 96103 – computer based testing (not an hourly code)
CPT 96118 – neuropsychological testing by psychologist, 96119 – neuropsychological testing by technician, 96120 — neuropsychological computer based testing

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Provider Name: ________________________________

Provider Degree and License: ________________ Provider ID: ________________________

Telephone: ________________________ Fax: ________________________

Address: ____

________________________ ________________

Signature Date

I will provide or supervise all direct clinical services to this patient and obtain necessary written release of information required for ValueOptions-TRICARE. Authorization of psychological testing is governed by TRICARE/ValueOptions Policy.

02/2006

FEB-07-2007 WED 10:02 AM TRICARE SOUTH/VALUEOPTNS FAX NO. 904 519 8274 P. 02