sunflower health plan

Medicaid | Marketplace | Medicare

Sunflower Product Line:

- ☐ KanCare (Medicaid)
- ☐ Ambetter (Health Insurance Marketplace)
- ☐ Allwell (Medicare Advantage)

SUBMIT TO
Utilization Management Department
Phone: 1-877-644-4623 Fax: 1-844-824-7705

NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date _____

PATIENT INFORMATION

Name _____

Date of Birth _____

Member ID# _____

Social Security # _____

Health Plan # _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider Tax ID# _____ NPI# _____

Fax# _____ Phone# _____

Referral Source _____

PROVISIONAL DSM-V DIAGNOSIS

The provider must report all diagnoses being considered for this patient.

Primary _____ R/O _____ R/O _____

Secondary _____

MEDICAL INFORMATION

1. Testing is intended to answer these specific questions: _____
2. These questions cannot be answered by a comprehensive clinical evaluation and would be answered more quickly by testing?
   ☐ Yes ☐ No Details: _____
3. How will the test results will be used to determine or modify treatment or evaluate response to treatment? _____
4. Is cognitive impairment suspected or confirmed? ☐ Yes ☐ No Other: _____
5. Is this a preoperative neuropsychological testing request related to surgical resection, transection, or thermal ablation for epilepsy?
   ☐ Yes ☐ No Other: _____
6. Has the member received a medical or neurological evaluation in the past six months? ☐ Yes ☐ No Other: _____
7. If yes for number 6, did the evaluation show cognitive deficits identified by screening test or obvious functional impairment? ☐ Yes ☐ No
8. If yes for number 6, did the evaluation show symptoms are not expected to respond to acute or medical treatment or to resolve without treatment? ☐ Yes ☐ No Details: _____
9. Is patient on medication known to cause cognitive impairment and medication cannot be discontinued? ☐ Yes ☐ No
10. Is patient on medication and it's unknown whether drug effects are a cause of cognitive impairment? ☐ Yes ☐ No
11. Is patient on medication and drug effects ruled out as cause of cognitive impairment? ☐ Yes ☐ No
12. Does the patient have a substance-use disorder and sufficient length of abstinence before testing? ☐ Yes ☐ No
13. Is it suspected or confirmed that the member has experienced any of the following?
    - ☐ Traumatic brain injury confirmed by imaging or history of head injury with altered consciousness or post-traumatic amnesia
    - ☐ Anoxic or hypoxic brain injury or postoperative cognitive decline
    - ☐ History of intracranial surgery
    - ☐ Confirmed neurotoxin exposure
    - ☐ Stroke
    - ☐ Encephalitis or meningitis
14. If member has had a brain injury, did it occur more than 30 days ago? ☐ Yes ☐ No Other: _____
15. If the member has had a brain injury, were symptoms present within the first 30 days and have persisted? ☐ Yes ☐ No
    Details: _____
16. Has the patient had any previous neuropsychological testing? ☐ Yes ☐ No Details: _____

17. If yes for number 14, has the patient received a lifetime number of testing episodes more than two? ☐ Yes ☐ No

18. If yes for number 14, was a neurologic deficit confirmed by previous testing? ☐ Yes ☐ No Details: _____

19. Has the member experienced an unexpected change in symptoms within last four months? ☐ Yes ☐ No

20. Has there been more than one testing episode within last 12 months? ☐ Yes ☐ No

21. Is retesting planned to evaluate response to new treatment? ☐ Yes ☐ No Details: _____

22. Is retesting planned to monitor rehabilitation or functioning? ☐ Yes ☐ No Details: _____

SERVICES REQUESTED

CODE REQUESTED	UNITS REQUESTED	TIME FRAME REQUESTED
Status exam:		
96116 (first hr)		
96121 (each additional hr)		
Test evaluation:		
96132 (first hr)		
96133 (each additional hour)		
Test administration and scoring:		
96136 (first 30 min)		
96137 (each additional 30 min)		
96138 (first 30 min)		
96139 (additional 30 min)		
Automated testing and Result:		
96146		

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

STANDARD REVIEW:
Standard 14-day time frame will be applied.

Clinician Signature Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature Date

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