



Provider must call BCBSIL at 800-851-7498 to verify benefits. To expedite the processing of your request, please complete all sections of the form.

For Inpatient Place of Service - Please fax at 972-239-7499.

For Outpatient Place of Service - Please fax to BCBSIL at 972-231-8118.

Request Submission Date: _____ Requested Testing Start Date: _____

Patient and Subscriber Information

Patient Name _____ Date of Birth _____
Subscriber Name _____ Subscriber ID # _____ Group # _____

Testing Provider Information

Medical Practitioner BH Practitioner Place of Service Inpatient Outpatient

Name _____ Licensure _____ NPI# _____
Address _____ City _____ State _____ Zip _____
Email Address _____ Phone # _____ Fax # _____
If requesting neuropsychological testing, are you a board certified neuro-psychologist? Yes No

Referral Information

Who referred the patient for testing? Name _____

Relationship to patient (i.e. PhD, PCP, Therapist, Medical Director, Parent, Psychiatrist, Teacher, School, etc.) _____

Assessment History

Have you met with the patient to complete a diagnostic evaluation? Yes No
Has a diagnostic evaluation been completed by another provider? Yes No
If yes, the diagnostic eval was completed by? Name _____ Date _____ License Type: _____
Has the patient had previous psychological testing? Yes, when? No Not sure
Focus of Previous Testing: _____

Current or Provisional Diagnosis

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____

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.

CPT Testing Code Requested:	Total Hrs Requested per CPT Code	Specify names of test attributed to this CPT Code:
1 <input data-bbox="142 541 300 630" type="text"/>	<input data-bbox="373 541 531 630" type="text"/>	
2 <input data-bbox="142 709 300 798" type="text"/>	<input data-bbox="373 709 531 798" type="text"/>	
3 <input data-bbox="142 877 300 966" type="text"/>	<input data-bbox="373 877 531 966" type="text"/>	
4 <input data-bbox="142 1045 300 1134" type="text"/>	<input data-bbox="373 1045 531 1134" type="text"/>	
5 <input data-bbox="142 1213 300 1302" type="text"/>	<input data-bbox="373 1213 531 1302" type="text"/>	

Total Hours for testing requested:

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____

