



**TRICARE REQUEST FOR PSYCHOLOGICAL /
NEUROPSYCHOLOGICAL TESTING**

Prior authorization only required for over 6 units per fiscal year. Network providers can submit clinical via the web at www.humana-military.com. For beneficiaries with a primary diagnosis of 290-319, fax this form to **866-811-4422**. Diagnoses outside this range are reviewed by Humana Military.

Patient's Name: _____ DOB: _____ Sponsor's #: _____

Referral Source: _____ Specialty: _____

Current level of care: Outpatient Inpatient (does not require a separate authorization for an approved Inpatient stay) Other _____

Referral question to be answered:

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.

Provisional Diagnosis(es):

Axis I:

Axis II:

Axis III:

Current Symptomatology (frequency, intensity, and duration):

Proposed Testing:

Name of Test:

Requested CPT Code:

Proposed Date(s) for Testing:

Provider Name: _____

Provider Degree and License: _____ Provider ID: _____

Telephone: (____) _____ Fax: (____) _____

Signature

Date

I will provide or supervise all direct clinical services to this patient. Authorization of psychological testing is governed by TRICARE/ValueOptions Policy.

Disclaimer: Authorization indicates that ValueOptions has determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered.