



### TRICARE REQUEST FOR PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING

This form is to be sent to fax number **1-866-811-4422** only for beneficiaries with a primary diagnosis of **290.0-314.9**. Diagnoses out of this range should be forwarded to Humana Military Healthcare Services for processing.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sponsor's #: \_\_\_\_\_

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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.

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Provisional Diagnosis(es):

Axis I:

Axis II:

Axis III:

Current Symptomatology (frequency, intensity, and duration):

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Proposed Testing:

Name of Test:

Requested CPT Code:

Proposed Date(s) for Testing:

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Provider Name: \_\_\_\_\_

Provider Degree and License: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

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.

**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.**