

# Psychological or Neuropsychological TESTING REQUEST FORM



BlueCross BlueShield  
of Oklahoma

Provider must call BCBSOK at 877-906-6389 to verify benefits. Fax to BCBSOK at 877-361-7660, or right fax at 312-946-3738.

Date \_\_\_\_\_

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

Testing Provider Information	
Name _____	Licensure _____ NPI# _____
Address _____	City _____ State _____ Zip _____
Email Address _____	Phone # _____ Fax # _____
If requesting neuropsychological testing, are you a board certified neuro-psychologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a diagnostic evaluation been completed by another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, the diagnostic eval was completed by? Name _____ Date _____ License Type: _____
Has the patient had previous psychological testing? <input type="checkbox"/> Yes, when? _____ <input type="checkbox"/> No <input type="checkbox"/> Not sure
Focus of Previous Testing: _____

Current or Provisional DSM-IV Diagnosis
Axis I: _____ Description: _____
Axis II: _____ Description: _____
Axis III: _____ Description: _____
Axis IV: _____ Description: _____
Axis V: Current _____ Highest Past Yr. _____
Medications _____

What clinical/referral question(s) needs to be answered by testing? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What aspects of this question cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*PSYT\*

