MERCY MANAGED BEHAVIORAL HEALTH
1000 DES PERES ROAD, SUITE 200C
ST. LOUIS, MO 63131
PHONE: 314.729.4600/800.413.8008 FAX: 314.729.4636

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING REQUEST FORM

INSURANCE:_____ **PATIENT NAME:**_____

Patient DOB:_____ **MEMBER NAME:**_____

MEMBER INSURANCE ID #:_____

PSYCHOLOGIST REQUESTING/PERFORMING TESTING:_____

Billing NPI #:_____ **Ind. NPI #:**_____ **TIN #:**_____

PHONE #:_____ **FAX #:**_____

ADDRESS:_____**City:**_____**State:**____**Zip:**_____

ICD 10 DIAGNOSES:_____

TESTS TO BE PERFORMED TOGETHER WITH CPT CODE FOR EACH TEST:

TEST NAME	CPT CODE FOR TEST	TEST NAME	CPT CODE FOR TEST

NUMBER OF UNITS REQUESTED FOR EACH CPT CODE:

96116 (1ST HOUR ONLY)_____ **96133 (HOURS)**_____

96121 (HOURS)_____ **96136 (1ST HALF HOUR ONLY)**_____

96130 (1st HOUR ONLY)_____ **96137 (HALF HOUR UNITS)**_____

96131 (HOURS)_____ **96138 (1ST HALF HOUR ONLY)**_____

96132 (1ST HOUR ONLY) _____ **96139 (HALF HOUR UNITS)**_____

96146 (ONE UNIT MAXIMUM)_____

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING REQUEST FORM (CONTINUED)

WHAT IS THE CLINICAL QUESTION THAT NEEDS TO BE ANSWERED?_____

_____

WHAT ARE THE CURRENT SYMPTOMS RELATED TO THE TESTING QUESTION?:_____

_____

HOW WILL THE RESULTS OF TESTING CHANGE THE TREATMENT PLAN?_____

_____

_____

HAS THE PATIENT HAD PREVIOUS TESTING? YES_____ MOST RECENT DATE OF TESTING_____

NO_____

HAS THE PATIENT BEEN EVALUATED BY A PSYCHIATRIST? YES____ MD NAME_____

NO____

PRIOR TREATMENT OR ANY ADDITIONAL CLINCIAL INFORMATION TO SUPPORT TESTING REQUEST:

_____

_____

_____

HAS A TESTING DATE BEEN SCHEDULED? YES_____ DATE_____

IF YES, PLEASE INDICATE SCHEDULED DATE NO_____

PLEASE FAX THIS FORM TO: (314) 729-4636 ATTENTION: MBH OPERATIONS