easterseals
Capital Region & Eastern Connecticut

Neuropsychological Testing Prescription Form

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____

Email Address: _____ Home Ph #: _____ Cell Ph #: _____

Insurance: _____ Policy ID: _____ Subscriber: _____

Patient's Preferred Language (*note, all testing is completed in English*): _____

Does the patient have a conservator/guardian (*for patients ≥ 18 years old*)? ☐ No ☐ Yes

If yes, list name & contact information of conservator: _____

☐ Neuropsychological Testing

Current/Active ICD-10 Diagnoses: _____

Rule Out ICD-10 Diagnoses: _____

Reason for Referral (include onset and progression of current concerns prompting referral): _____

_____

Attach the following information to avoid a delay in processing and scheduling:

☐ Copy of patient's insurance information, including policy ID and insurance subscriber name
☐ Recent medical/clinical notes which support medical necessity of neuropsychological testing
☐ List of active medications
☐ Copy of any diagnostic testing results if applicable (e.g., brain MRI, prior neuropsychological testing, etc.)

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*I certify that Neuropsychological Testing is **medically necessary** for my patient.*

MD* Name (**please print**):		NPI:	
MD* Signature:		Date:	
MD* Phone Number:		Fax:	
MD* Address:			
MD* Email Address (for communication with our provider and/or to receive results):			

*In lieu of MD, acceptable referring providers include: DO, PA, APRN, LCSW.

To avoid delay in scheduling, please include copy of relevant medical/clinical records that help substantiate reason for referral and medical necessity of the evaluation (required for insurance authorization purposes).

Return via fax to 860-748-4432. Thank you!