KAISER PERMANENTE®

Mental Health Services
Neuropsychological/Psychological Testing Authorization Request

>> Incomplete forms may delay authorization <<

Please fax completed form to the Mental Health Access Center (MHAC) fax number listed below. Providers may request urgent reauthorization by calling first, then faxing the form. **MHAC Fax: 206-630-1683** / Phone: 206-630-1680
Mailed forms are accepted as well: Kaiser Foundation Health Plan of Washington, P.O. Box 9009, Renton WA 98057-9859

Practitioner Name / License: _____ **Patient Name:** _____

Practitioner NPI: _____ **Patient Medical Record Number:** _____

Agency/Group: _____ **Patient Date of Birth:** _____

Site Address: _____ **Authorization Start Date Needed:** _____

Mailing Address: _____

Phone Number: _____ **Today's Date:** _____

FAX Number: _____

TIN: _____

1. Reason for testing: _____
2. Who initiated the referral? _____
3. What are the referral questions? _____
4. Describe how the treatment plan will be affected by the results of testing: _____
5. What are the possible diagnoses under consideration? _____
6. History of patient (include any past psychological testing, dates and results): _____
7. Describe the results of treatment to date and the reason testing is indicated at this time: _____

CONFIDENTIAL **This information can be disclosed only with written consent of the person to whom it pertains or is otherwise permitted by such regulations (Uniform Health Information Act Title 70.02)**

8. List tests being requested (do not use abbreviations):

Name of Test	To Measure or Answer What?

Type of Testing Requested (check one): ☐ Psychological Testing ☐ Neuropsychological Testing

Number of units being requested for each code:

Code:_____ # of units:_____

Code:_____ # of units:_____

Code:_____ # of units:_____

Code:_____ # of units:_____

Code:_____ # of units:_____

Code:_____ # of units:_____

Code:_____ # of units:_____

9. Comments: _____

_____

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Person Completing Form: _____ _____

Name, Title (print) Signature

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