Companion
BENEFIT ALTERNATIVES

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www.CompanionBenefitAlternatives.com

CBA Psychological/Neuropsychological Testing Initial Preauthorization Request Form

☐ **Please check here if this testing is for Autism Spectrum Disorders**

Please type or print clearly. Incomplete or illegible forms may delay processing.

CBA reserves the right to request additional clinical information if further testing is requested.

***Required information**

Clinician's First Name*: ____________________________ Clinician's Last Name*: ____________________________

Licensure*: _____________ Phone Number*: __________________ Fax Number*: ____________________

Mailing Address*: ____

City*: ________________________ State*: ____________________ ZIP Code*: ___________________

Email: ____

Clinician's NPI*: ________________________________ Group's NPI: ________________________________

Patient's First Name*: ____________________________ Patient's Last Name*: _________________________

Date of Birth*: __________________________________ ID Card Number*: ____________________________

Primary Psychiatric Diagnosis*: _________________________ Rule Out Diagnosis 1: ______________________

Rule Out Diagnosis 2: _________________________________ Rule Out Diagnosis 3: ______________________

Medical Diagnosis: ___________________________________ Axis V: Current GAF*: ______________________

Referral Source*: ____

Number of Testing Hours Requested: _______________________

CPT Code Requested*(please check): ___ 96116 ___ 96121 ___ 96130 ___ 96131 _____ 96132
___ 96133 ___ 96136 ___ 96137 ___ Other: ___________________

Date of Testing*: ____

Is testing for educational purposes?*: ___ Yes ___ No

If yes, explain: ____

List each test name and hours per test along with functional limitations and clinical information*:

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®Registered Mark of Companion Benefit Alternatives, Inc.

Signature of Licensed Psychologist

Date

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