Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
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 Units 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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Signature of Licensed Psychologist Date