Psychological and Neuropsychological Evaluation Behavioral Health Authorization Form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

○ Psychological Evaluation ○ Neuropsychological Evaluation

Send Authorization Requests via: Fax: 541-296-1036 or SECURE Email: um@gobhi.org
If you have behavioral health authorization form questions, please call 1-541-298-2101.

Documentation Required *Check to confirm that each of these required items is included in your request:*

☐ **Assessment** ☐ **Service plan** ☐ **Progress notes**

Date of Request: _____

Member Name				
Date of birth (mm/dd/yyyy)	OHP number		Member Phone Number	
Member Address				
Provider/Facility	Address	City	State	Zip
Primary Contact	Phone	Email	Fax	
Preferred method of contact ☐ Phone ☐ Email ☐ Fax				
Start Date	End Date		Current Diagnosis Code	

CPT code(s):	Units/Days:	CPT code(s):	Units/Days:
CPT code(s):	Units/Days:	CPT code(s):	Units/Days:
CPT code(s):	Units/Days:	CPT code(s):	Units/Days:
CPT code(s):	Units/Days:	CPT code(s):	Units/Days:

How is testing going to be utilized at this time?		
What question(s) are hoping to be answered from testing; that cannot be answered by medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy or other assessment cannot?		
Medical, neurologic, mental status, and psychiatric exams and testing (e.g. CT scan, MRI) have been completed as indicated. Yes No		
Has a standard clinical evaluation been completed in the past? ☐ Yes ☐ No If yes, date _____	By whom	Why is testing necessary now?
What are the possible comorbid or alternative diagnoses?		
List all relevant or neurological psychiatric conditions suspected or confirmed:		

Relevant results of imaging or other diagnostic procedures (provide dates and types of each):
Psychological testing are judged likely to affect care or treatment of member: ☐ Yes ☐ No
Neurological testing is needed due to cognitive or behavior impairment: ☐ Yes ☐ No
Patient is able to participate as needed in the testing: ☐ Yes ☐ No
Neuropsychological is needed to aid in diagnostic or exclusion of organic or behavioral health disorder: ☐ Yes ☐ No
Is medication effects a likely and primary cause of the impairment being assessed: ☐ Yes ☐ No
Is substance abuse/dependence suspected: ☐ Yes ☐ No If yes, how many days of sobriety? _____

Provider Information

Accurate information is needed for processing claims and credentialing purposes. The Rendering Practitioner (individual/licensed clinician) and Billing Facility (facility/clinic that is billing for the services) must be registered with the State of Oregon at the time of service in order to receive payment.

Billing Facility
Name
Tel #
Fax #
TIN #
OR Medicaid Provider #
NPI #
Billing Address
Rendering Provider
Name (As spelled on professional license)
Professional License/Title
License # and Issuing State
TIN #
OR Medicaid Provider #
NPI #
Physical Address

Provider/Facility Authorized Signature

Date

Ready to submit?

Eastern Oregon CCO Claims
EOCCO, P.O. Box 40384, Portland, OR 97240
Questions? Call 888-788-9821.

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