

# Psych / Neuropsych Testing Intake Information

Provider:

Appointment date:

Patient Name:

## **Referring MD or other referring provider:**

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Doctor Name:

Doctor Street Address:

City, State, Zip:

Doctor Phone #:

Doctor NPI #:

## **Testing to be performed/Services requested:**

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### Mental Health:

90791: (# hours):

96101 (# hours):

96102 (# hours):

96103 (# hours):

90832 (# hours):

90834 (# hours):

90837 (# hours):

90846-90847 (# hours):

Other codes (# hours):

Diagnosis/diagnoses being tested:

### Medical/Neuropsychology:

96116 (# hours):

96118 (# hours):

96119 (# hours):

96120 (# hours):

Other codes (# hours):

Diagnosis/diagnoses being tested: