Electroconvulsive Therapy (ECT) Request Form

Submit **fax to 1-888-656-3510**

Date of Request: _____ Initial: ☐ Concurrent: ☐

Member Information

Member Name: _____ DOB: _____ Member ID: _____

Subscriber Name: _____ Subscriber ID: _____ Group #: _____

Provider Information

Facility/Provider Name: _____ NPI #: _____

Address: _____ Phone #: _____

_____ Fax #: _____

Name/Credentials of Medical Practitioner Performing ECT: _____

ECT History

Past ECT? Yes ☐ No ☐ If yes, was ECT within past 6 months? Yes ☐ No ☐

Date(s) of Past ECT: _____ N/A ☐ Frequency of Past ECT: _____ N/A ☐

Authorization Request for ECT

Type of ECT: Unilateral ☐ Bilateral ☐ CPT Code: _____ Planned ECT Frequency: _____

Start Date: _____ Planned ECT End Date: _____ Total Sessions Requested: _____

Response to Most Recent ECT Session: Length: _____ Length of Convulsion: _____

Current Diagnoses

ICD-10 Code: _____ Description: _____

ICD-10 Code: _____ Description: _____

ICD-10 Code: _____ Description: _____

Behavioral Health Treatment History

Level(s) of Care (select all that apply): Inpatient ☐ RTC ☐ PHP ☐ IOP ☐ OP ☐ # Inpatient Admissions: _____

Current/Most Recent Behavioral Health Treatment

Level of Care: _____ Dates of Service: _____

Current Medications/Dosage

_____

Provider Name/Title (print): _____

Provider Signature: _____ Date: _____

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