Magellan HEALTHCARE SM

Subsequent ECT Request Form
Fax to Magellan: 1.888.656-4916

Form to be completed by the MD who will administer ECT

Today's Date: _____ Requesting MD Name: _____

Contact Phone number: _____ MIS # for Authorization: _____

Member Name: _____ Medicaid ID Number: _____

Updated Diagnosis: – DSM (current version):

_____

_____

_____

_____

Describe current response to ECT treatment:

_____

_____

_____

Are clinical symptoms improving with ECT? If yes, detail improvements below: ☐ Yes ☐ No

_____

_____

Has member experienced or complained about side effects? If yes, explain below: ☐ Yes ☐ No

_____

_____

_____

How many additional treatments are currently recommended? _____

Is member continuing to consent to additional ECT treatments? If no, explain below: ☐ Yes ☐ No

_____

Current Medications:

Name of Medication	Dose	Frequency	Prescribing Clinician

Is maintenance ECT planned? If yes, indicate expected number of sessions and frequency: ☐ Yes ☐ No

_____

_____

I verify that the information provided within this report is an accurate representation of the member's status and that I am privileged to administer this procedure.

Physician Signature: _____ Date: _____