SUBMIT TO

Utilization Management Department

Phone: 1.888.713.6180 Fax: 1.877.725.7751



ELECTROCONVULSIVE THERAPY (ECT) AUTORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Hospital where ECT will be performed Professional Credential:	DEMOGRAPHI	CS					PROVIDER INFORMATION			
Professional Credential: MD PhD Other Physical Address Phone Fax Phone	Patient Name						Provider Name (print)			
Professional Credential: MD PhD Other Physical Address Phone Fax Physical Address Phone Fax Physical Address Phone Fax Physical Address Phone Fax Phone	DOB						Hospital where ECT will be performed			
Potient ID							Professional Credential:	MD □ PhD □ Other		
Phone Fax							Physical Address			
TPI/NPI # Tax ID #	Patient ID						Phone	Fax		
Tax ID # REQUESTED AUTHORIZATION FOR ECT										
REQUESTED AUTHORIZATION FOR ECT Please indicate type(s) of service provided by YOU and the first names and dates, include hospitalizations Substance Abuse None By History and/or Current/Active Type Bilateral Unilateral Substance(s) used, amount, frequency and last used Frequency Date first ECT Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization PCP COMMUNICATION Has information been shared with the PCP regarding Behavior Provider Contact Information, Date of Initial Visit, Presenting Filter CURRENT RISK/LETHALITY Diagnosis, and Medications Prescribed (if applicable)? PCP communication completed on via: Phone Fax Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination from patient/guardian Pasteriars Coordination from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian Pasteriars Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/gua	PREVIOUS BH/	SUD TR	EATMENT							
List names and dates, include hospitalizations Please indicate type(s) of service provided by YOU and the fi Total sessions requested Type Bilateral	□None or □O	P MH	H □SUD (and/or 🗆	IP 🗆 MH [□SUD				
Total sessions requested	List names and dates, include hospitalizations									
Substance Abuse None By History and/or Current/Active Substance(s) used, amount, frequency and last used Frequency Date first ECT Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization Frimary Interfact Frequency Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization Frequency Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization Frequency Date list ECT Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization Frequency Date first ECT Date last ECT Est. # of ECTs to complete treatment Requested start date for authorization Frequency Date first ECT Date last ECT Est. # of ECTs to complete treatment Frequency Date last ECT Est. # of ECTs to complete treatment Frequency Est. # of ECTs to complete treatment Frequency Date last ECT Est. # of ECTs to complete treatment Frequency Date last ECT Date last ECT Date last ECT Est. # of ECTs to complete treatment Frequency Est. # of ECTs to complete treatment Frequency Est. # of ECTs to complete treatment Frequency Date list ECT Date last ECT Est. # of ECTs to complete treatment Frequency Est. # of ECTs to complete freatment Frequency Est. # of ECTs to complete freatment Frequency Date last ECT Date last ECT Date last ECT Est. # of ECTs to complete freatment Frequency Est. # of ECTs to complete freatment Frequency Est. # of ECTs to complete freatment Frequency Date last ECT Date last ECT Est. # of ECTs to complete freatment Frequency Frequency Date last ECT Date last ECT Date last ECT Est. # of ECTs to complete freatment Frequency Frequency Frequency Frequency Date last ECT Est. # of ECTs to complete freatment Frequency Frequency Frequency Frequency Frequency Frequency Frequency Frequency Frequency Date last ECT Est. # of ECTs to complete freatment Frequency Frequency Frequency Frequency Frequency Frequency Frequency Frequency Frequency Fr							,, ,,		•	
Substance(s) used, amount, frequency and last used	Substance Abuse □ None □ By History and/or □ Current/Active						•			
CURRENT ICD DIAGNOSIS Primary R/O R/O R/O Length Length of convulsion Tertiary PCP COMMUNICATION Additional Provider Contact Information, Date of Initial Visit, Presenting For Current Response on via: Phone Fox Member Refused By Homicidal Providers Assault/ Violent Responsion Date last ECT Date last ECT Set. # of ECTs to complete treatment Requested start date for authorization Requested start date for authorization Requested start date for authorization PCP COMMUNICATION Has information been shared with the PCP regarding Behavior Provider Contact Information, Date of Initial Visit, Presenting Fox Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian										
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Primary R/O R/O Length Length of convulsion Tertiary Additional CURRENT RISK/LETHALITY Diagnosis, and Medications Prescribed (if applicable)? PCP communication completed on via: Phone Fax Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian										
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Secondary	Primary							2011011	_	
Tertiary	R/O R/O									
Additional	Secondary						Length L	ength of convulsion		
Additional	Tertiary						PCP COMMUNICATION			
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Suicidal Phone Fax Suicidal Phone Fax Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian	Additional						Provider Contact Information, De	ate of Initial Visit, Presenting Proble	m,	
Suicidal	CURRENT RISK	/LETHA	LITY				Diagnosis, and Medications Pres	cribed (if applicable)?		
Homicidal Coordination of care with other behavioral health providers? Assault/ Violent Has informed consent been obtained from patient/guardian	Suicidal						PCP communication completed	lon via: □Phone □Fax □] Mail	
Assault/ Violent Rehavior Assault Violent Coordination of care with other behavioral nealin providers? Has informed consent been obtained from patient/guardian	oolelaal						Member Refused By			
Polyguior	Homicidal						Coordination of care with other	behavioral health providers?		
Pohovior	Assault/ Violent	П	П	П	П	П	Has informed consent been obto	ained from patient/guardian?		
	Behavior	_	_				Date of most recent psychiatric	evaluation		
Psychotic Date of most recent physical examination and indication of a							Date of most recent physical exc	amination and indication of an		
Symptoms anesthesiology consult was completed	Symptoms						anesthesiology consult was com	pleted		

CURRENT PSYCHOTROPIC MEDICATIONS				
Name	Dosage	F	requency	
	·i	i		:
PSYCHIATRIC/MEDICAL HISTORY				
Please indicate current acute symptoms member	is experiencing			
Please indicate any present or past history of medi	ical problems including allergia	es, seizure history and it	f member is pregnant	
REASON FOR ECT NEED				
Please objectively define the reasons ECT is warro	anted including failed lower le	evels of care (including	g any medication trials)	
Please indicate what education about ECT has b	peen provided to the family a	nd which responsible	party will transport patient to	ECT appointment
ECT OUTCOME				
Please indicate progress member has made to	date with ECT treatment			
Ticase indicate progress member has made to	date with Let itedifficin			
ECT DISCONTINUATION				
Please objectively define when ECTs will be disco	ontinued – what changes will h	nave occured		
Please indicate the plans for treatment and med	lication once ECT is complete	d		
STANDARD REVIEW:		EXPEDITED REVIEW : B	y signing below, I certify that	applying the
Standard 14-day time frame will be applied.			e frame could seriously jeopo e or ability to regain maximur	
		mombol should, inc	or ability to regain maximor	monenon.
Clinician Signature	Date	Clinician Signature	D	ate
		SUBMIT TO Utilization Man	agement Department	
			0 / 100 5 1 077 705 7751	

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