mhs health wisconsin™

SUBMIT TO
Utilization Management Department
PHONE 1.800.589.3186 | FAX 1.866.694.3649

ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION FORM

*ALL FEILDS MUST BE COMPLETED FOR THIS REQUEST TO BE REVIEWED.
Please type or print neatly.

INPATIENT OUTPATIENT

DEMOGRAPHICS

Patient Name: _____

Health Plan: _____

DOB: _____

Patient ID #_____

Last Auth #_____

PREVIOUS BH/SA TREATMENT

☐ None or ☐ OP ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA
List names and dates, include hospitalizations: _____

_____

_____

_____

Substance Use Disorder: ☐ None ☐ By History &/or ☐ Current/Active

Substance(s) used, amount, frequency and last used: _____

_____

_____

_____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

PRIMARY MEDICAL PHYSICIAN (PMP) COMMUNICATION

Has information been shared with the PMP regarding:

The initial evaluation & treatment plan? ☐ Yes ☐ No

This updated evaluation & treatment plan? ☐ Yes ☐ No

PMP Name/Date last notified:_____

If No, explain:_____

_____

PROVIDER INFORMATION

Please indicate to whom the authorization should be made:

Individual Provider ☐ Yes ☐ No Group/Facility ☐ Yes ☐ No

Provider Name (print) _____

Professional Credential: ☐ MD ☐ PhD ☐ Other _____

Physical Address_____
(street address, city, state, zip code)

_____

_____

Phone# _____ Fax#_____

Hosptial where ECT will performed: _____

_____

Medicaid/TPI/NPI# _____

Medicaid Tax ID#_____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW *	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/ Violent Behavior	☐	☐	☐	☐	☐
Psychotic Symptoms:	☐	☐	☐	☐	☐

*3, 4, or 5please describe what safety precautions are in place

_____

_____

_____

_____

_____

PCP COMMUNICATION

Has information been share with the PMP regardinf Behavioral Health Provider Contanct information. Date of initial Visit, presenting Problem, Diagnosis and Medications Perscribed (if applicable)?

PMP communication completed on _____via: Phone☐ Fax☐ Mail ☐

Member Refused By: _____
(signature/Title)

Coordination of care with other behavioral health providers?

Has informed consent been obtained from patient/gaurdian?_____

Date of most recent psychiatric evaluation: _____

Date of most recent physical exawmination and indication if an anesthesiology consult was compleated: _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of services provided **BY YOU** and the frequency):

Total sessions requested: _____

_____

Type: _____ Bilateral _____ Unilateral

Frequency: _____

Date first ECT: _____ Date first ECT:_____

Est. # of ECTs to complete treatment: _____

Requested start date for authorization?_____

Last ECT info: Length: _____

Lenght of convulsion: _____

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

DISCHARGE GOALS

Please indicate current accute syptoms member is Experiencing:

_____

Please inidicate any present or past histroy of medical problems including allergies, seizure history and if member is pregnant:

_____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including and medicaton trials):

_____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments:

_____

ECT outcome
Please indicate progress member has made to date with ECT treatment:

_____

ECT discontinuation
Please objectively define when ECT will be discontinued-- what changes has occured:

_____

Please indicate the plans for treatment and medications once ECT is completed:

_____

Provider Name _____ Provider Signature _____ Date