

Electroconvulsive Therapy Prior Authorization Reques

To request electroconvulsive therapy (ECT) services, please submit this form electronically at <https://www.availity.com> or via fax to 1-877-434-7578.

Member information					
Name					
Member number		Date of birth			
Address					
City, State		ZIP code			
Provider information					
Facility name			Facility NPI		
UM rep. contact		Phone		Fax	
Discharge planner name		Phone		Fax	
Attending provider name			Attending provider NPI #		
Facility status	Stage of treatment		Location of treatment		
<input type="checkbox"/> Participating provider	<input type="checkbox"/> Initial ECT series		<input type="checkbox"/> Inpatient ECT		
<input type="checkbox"/> Nonparticipating provider	<input type="checkbox"/> Continuation of treatment		<input type="checkbox"/> Outpatient ECT		
Facility TIN		Dates of service		Number of treatment(s)	
Medical clearance for ECT treatment					
Provider name			Date assessment completed		
Medical clearance				<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	
Second opinion				<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	

Diagnoses (Include all behavioral health and physical health.)				
Reason member was referred for ECT				
Current risk factors				
Suicide				
<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Intent without means	<input type="checkbox"/> Intent with means	<input type="checkbox"/> Contracted not to harm self
Homicide				
<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Intent without means	<input type="checkbox"/> Intent with means	<input type="checkbox"/> Contracted not to harm others
Abuse				
Physical or sexual abuse or child/elder neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, patient is:	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> Neither, but abuse exists in family			
Abuse has been legally reported	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Abuse or neglect involves a child or elder	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Explain any significant history of suicidal, homicidal, impulse control or other behavior that may impact the patient's level of functioning.

Current mental status exam

Substance use assessment

Treatment history

Current treatment team	Name	Phone
PCP		
Psychiatrist		
Anesthesiologist		
Psychologist		
ARNP		
Social worker		

Other		
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History of inpatient treatment

Treatment compliance

Social support (Who will care for patient following treatment?)

Medication information

Current medications (Include behavioral and physical health medications or submit a medication administration record.)

Drug	Dose	Frequency

History of medications tried in the past and results

Does patient have a history of poor response to several trials of antidepressants in adequate doses for a sufficient time? Yes No
If yes, provide details:

Does patient have a history of a good response to ECT during an earlier episode of illness? Yes No
If yes, provide details:

Does patient have a history adverse effects with medication that are deemed to be less likely and/or severe with ECT? Yes No
If yes, provide details:

Recent ECT treatment record (for continued care review)

Date	Provider name	Pretreatment score (for example, QUID, PHQ-9, etc.)	Unilateral/bilateral	Seizure duration	Response

Provider signature:	Date:
Phone:	Fax:

Disclaimer: Authorization indicates that MCG medical necessity guidelines have been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

Protected Health Information (PHI)

These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at 1-866-805-4589.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

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