

SUBMIT TO

Utilization Management Department

Phone: 1.866.912.6285 Fax: 1.877.725.7751

ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION REQUEST FORM

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

Provider Name [print]	DEMOGRAPHI	ICS					PROVIDER INFORMATION			
Professional Credential:	Patient Name						Provider Name (print)			
Policitant ID	DOB						Hospital where ECT will be performed			
Potient ID							Professional Credential: MD PhD Other			
Phone							Physical Address			
TPI/NPI # TRAINER TR	Patient ID									
None or OP MH SUD and/or IP MH SUD			FATAIENIT							
REQUESTED AUTHORIZATION FOR ECT	PKENIOU2 BH/	SUD IK	EAIMENI				Tax ID #			
Please indicate type(s) of service provided by YOU and the frequency. Total sessions requested Type Bilateral Uniliateral Bilateral Uniliateral Bilateral Uniliateral Bilateral Uniliateral Bilateral Uniliateral Bilateral Date last ECT Date last ECT Date last ECT Bilateral Est. # of ECTs to complete treatment Requested start date for authorization Earthury Diagnosis, and Medications Prescribed (if applicable)? PCP communication completed on via: Phone Fax Maliformation for are with other behavioral health providers? Has informed consent been obtained from patient/guardian? Behavior Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most recent physical examination and indication of an Date of most re	□None or □O	P MH	H □SUD (and/or 🗆	P□MH [□SUD				
Substance (s) used, amount, frequency and last used	List names and dates, include hospitalizations									
Substance(s) used, amount, frequency and last used							Total sessions requested			
CURRENT ICD DIAGNOSIS Primary	Substance Abuse	∍□None	e □ By Histo	ory and/or	☐ Curren	t/Active	Type Bilateral Unilateral			
Est. # of ECTs to complete treatment Requested start date for authorization Requested start date for authorization Last ECT INFO Length Length of convulsion PCP COMMUNICATION Has information been shared with the PCP regarding Behavioral Health Additional Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)? PCP communication completed on via: Phone Fax Mail Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian? Date of most recent physical examination and indication of an	Substance(s) use	d, amou	ınt, frequer	ncy and las	t used		Frequency			
Primary R/O R/O Length Length of convulsion Secondary Teritary Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)? FOR communication completed on via: Phone Fax Mail Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian? Assault/ Violent Behavior Psychotic Date of most recent physical examination and indication of an							Date first ECT Date last ECT			
Requested start date for authorization	CURRENTICE	DIACN	OCIC				Est. # of ECTs to complete treatment			
R/O							Requested start date for authorization			
Length Length of convulsion Length of convulsion							LAST ECT INFO			
PCP COMMUNICATION Additional							Length Length of convulsion			
Additional							PCP COMMUNICATION			
CURRENT RISK/LETHALITY Diagnosis, and Medications Prescribed (if applicable)? PCP communication completed on via: Phone Fax Mail Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian? Date of most recent psychiatric evaluation Date of most recent physical examination and indication of an							Has information been shared with the PCP regarding Behavioral Hea			
Suicidal Suicidal PCP communication completed on via: Phone Fax Mail Member Refused By Coordination of care with other behavioral health providers? Has informed consent been obtained from patient/guardian? Psychotic Psychotic Date of most recent physical examination and indication of an	Additional						Provider Contact Information, Date of Initial Visit, Presenting Problem,			
Suicidal	CURRENT RISK	/LETHA	LITY				Diagnosis, and Medications Prescribed (if applicable)?			
Homicidal Coordination of care with other behavioral health providers? Assault/ Violent Behavior Psychotic Date of most recent physical examination and indication of an	0.1.1.1						PCP communication completed on via: \Box Phone \Box Fax \Box M			
Assault/ Violent Behavior Psychotic Date of most recent physical examination and indication of an	Suicidal	Ш		Ш		Ш	Member Refused By			
Psychotic Date of most recent psychiatric evaluation Date of most recent physical examination and indication of an	Homicidal						Coordination of care with other behavioral health providers?			
Psychotic Date of most recent psychiatric evaluation Date of most recent physical examination and indication of an	Assault/ Violent			П			Has informed consent been obtained from patient/guardian?			
Superstance	Behavior	Ш				Ш	Date of most recent psychiatric evaluation			
C. manata naa	Psychotic						Date of most recent physical examination and indication of an			
	Symptoms						anesthesiology consult was completed			

CURRENT PSYCHOTROPIC MEDICATIONS				
Name	Dosage		Frequency	
	<u>.i</u>			
PSYCHIATRIC/MEDICAL HISTORY				
Please indicate current acute symptoms member	is experiencing			
Please indicate any present or past history of med	ical problems including allergi	es, seizure history and	if member is pregnant	
REASON FOR ECT NEED				
Please objectively define the reasons ECT is warre	anted including failed lower le	evels of care (including	ng any medication trials)	
Please indicate what education about ECT has b	peen provided to the family a	ınd which responsible	party will transport patient to	o ECT appointment
ECT OUTCOME				
Please indicate progress member has made to	date with ECT treatment			
ECT DISCONTINUATION				
Please objectively define when ECTs will be disco	ontinued – what changes will	have occured		
riedse objectively deline when LC15 will be disco	ominoea – what changes wiii	nave occured		
Please indicate the plans for treatment and med	dication once ECT is complete	ed		
STANDARD REVIEW: Standard 14-day time frame will be applied.			By signing below, I certify tha ne frame could seriously jeop	
зтанаата 14-аау ште патте жи ве арриеа.			fe or ability to regain maximu	
Clinician Signature [Date	Clinician Signature	Г	Oato
Cirrician signatore L	Juic	Cirrician signature	L	Date
		:		
		SUBMIT TO Utilization Ma	nagement Department	

Phone: 1.866.912.6285 Fax: 1.877.725.7751