



SUBMIT TO:
Utilization Management Department
 PHONE 1.844.265.1278 FAX 1.844.481.6729

ELECTROCONVULSIVE THERAPY (ECT) Authorization Request Form

*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

Please indicate which level of care the member is currently engaged: INPATIENT OUTPATIENT

DEMOGRAPHICS

Patient Name _____
 Patient Last Name _____
 DOB _____
 SSN _____
 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 None By History and/or Current/Active
 Substance(s) used, amount, frequency and last used _____
Current ICD Diagnosis
 Primary (Required) _____
 Secondary _____
 Tertiary _____
 Additional _____
 Additional _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault/ Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

PROVIDER INFORMATION

Provider Name (print) _____
 Hospital where ECT will be performed _____
 Professional Credential: MD PhD Other _____
 Physical Address _____
 Phone _____ Fax _____
 TPI/NPI # _____ Tax ID # _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.
 Total sessions requested _____
Type Bilateral _____ Unilateral _____
 Frequency _____
 Date first ECT _____ Date last ECT _____
 Est. # of ECTs to complete treatment _____
 Requested start date for authorization _____

LAST ECT INFO

Length _____ Length of convulsion _____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health 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 (Signature/Title) _____
 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 anesthesiology consult was completed _____

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CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing

Please indicate any present or past history of medical problems including allergies, seizure history and member is pregnant

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication 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 ECTs will be discontinued – what changes will have occurred

Please indicate the plans for treatment and medication once ECT is completed

Provider Name (please print) _____

Provider Signature _____ Date _____

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