



500 Great Circle, Nashville, TN 37228 Tel. 1-866-780-8546 Fax 1.866-949-4846

**Electroconvulsive Therapy (ECT) Initial Treatment Request**

<b>Customer Name:</b>	<b>Today's Date:</b>
<b>Customer ID #</b>	<b>Date of Birth:</b>
<b>Patient currently hospitalized:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, Inpatient Auth #: A _____</b>

**Diagnosis (ICD 10 Codes)**


**ECT Services Requested**

**Requesting:**  Outpatient (# of units: \_\_\_\_\_)  Inpatient (# of units: \_\_\_\_\_) **Total Units requested:** \_\_\_\_\_

**Service start date:** \_\_\_\_\_ **Service end date:** \_\_\_\_\_

**If requesting inpatient ECT:** What prevents this service from being provided on an outpatient basis? \_\_\_\_\_

\_\_\_\_\_

**If requesting outpatient ECT:** Does the patient have adequate post-treatment support for outpatient to safely complete ECT on an outpatient basis? \_\_\_\_\_

\_\_\_\_\_

**Required Documentation**

*Please check to indicate that you have faxed the following information with this form.*

Order by the attending.

Informed Consent signed by the customer.

Psychotropic medications have been tried and have failed or are contraindicated for this patient (Include a list of medication and start/end dates).

A second opinion has been obtained by another physician.

This patient been cleared by a medical physician.

Signed Anesthesiology consent.

**Contact Information**

**Treating Provider name:** \_\_\_\_\_ **Facility:** \_\_\_\_\_

**Facility NPI#:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

*This authorization is for medical necessity only and not a guarantee of payment. Eligibility is determined at the time the claim is received and benefits are subject to the limitations and exclusions of the member's plan.*

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***Please fax completed form and accompanying documentation  
to the Behavioral Health Unit at 1-866-949-4846***

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