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

Electroconvulsive Therapy (ECT) Initial Treatment Request

Customer Name:	**Today's Date:**
Customer ID #	**Date of Birth**:
Patient currently hospitalized: ☐ Yes ☐ No	**If yes, Inpatient Auth #:** A _____

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.

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