

## *Electroconvulsive Therapy Prior Authorization Request*

To request electroconvulsive therapy (ECT) services, please submit this form electronically using our preferred method at <https://www.availity.com>\* or via fax to **1-844-430-1703**.

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

\* Availity, LLC is an independent company providing administrative support services on behalf of Blue Medicare Advantage.

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		

History of inpatient treatment

Treatment compliance

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

<b>Medication information</b>
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:
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Does patient have a history of a good response to ECT during an earlier episode of illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:				
Does patient have a history of adverse effects with medications that are deemed to be less likely and/or severe with ECT?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:				
<b>Recent ECT treatment record (for continued care review)</b>					
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.

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.