



SUBMIT TO:
Utilization Management Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
PHONE 1.877.687.1180
Inpatient Fax 844.561.7857
Outpatient Fax 844.256.1291

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 #

PROVIDER INFORMATION

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

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

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

CURRENT RISK/LETHALITY

Table with 5 columns: 1 NONE, 2 LOW, 3 MOD*, 4 HIGH*, 5 EXTREME*. Rows include Homicidal, Assault/ Violent, Behavior, Psychotic, Symptoms.

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

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 _____