ambetter. FROM illinicare health
Insured by Celtic Insurance Company

SUBMIT TO:
Utilization Management Department
PHONE 866-329-4701
FAX 844-528-3453

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 _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal	☐	☐	☐	☐	☐
Assault/ Violent	☐	☐	☐	☐	☐
Behavior	☐	☐	☐	☐	☐
Psychotic	☐	☐	☐	☐	☐
Symptoms	☐	☐	☐	☐	☐

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

_____

_____

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 occured

_____

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

_____

Provider Name (please print)_____

Provider Signature_____ Date_____