

### ***Electroconvulsive Therapy Prior Authorization Request***

To request electroconvulsive therapy (ECT) services, please submit this form electronically at <https://www.availity.com>\* or via fax to **844-430-1702**.

<b>Member information</b>		
Name:		
Member number:		Date of birth:
Address:		
City, State:		ZIP code:
<b>Provider information</b>		
Facility name:		
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:	Number of treatment(s):	
Dates of service:		
<b>Medical clearance for ECT treatment</b>		
Provider name:	Date assessment completed:	
Medical clearance:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	

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

<https://provider.amerigroup.com>

Second opinion:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
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Diagnoses (Include all behavioral health and physical health)		

Reason member was referred for ECT

Current risk factors
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Suicide
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<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
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Homicide
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<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
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Abuse
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Physical or sexual abuse or child/elder neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No
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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
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Abuse has been legally reported	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Abuse or neglect involves a child or elder	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Explain any significant history of suicidal, homicidal, impulse control, or other behavior that may impact the patient's level of functioning.

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Current mental status exam:

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Substance use assessment:

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**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?):

**Medication information**

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:

<p>Does patient have a history of poor response to several trials of antidepressants in adequate doses for a sufficient time?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	<p>If yes, provide details:</p>
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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 medication that are deemed to be less likely and/or severe with ECT? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide details:			
Recent ECT treatment record (for continued care review)					
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.

**Protected Health Information (PHI)**

These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at **800-499-9554**.

Providers: You are required to return, destroy, or further protect any PHI you receive pertaining to patients that you are not treating. You are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.