



500 Great Circle, Nashville, TN 37228

Tel. 1-866-780-8546

Fax 1-866-949-4846

Medicare Advantage 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 Required

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 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 has 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.

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.

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

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