Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered

Please Submit to the Dedicated Fax Line Below
Georgia Medicaid
Medicaid Only Members: 1-877-892-8213
Dual Eligible Members (Members with Medicaid Policies): 1-855-292-0233
Discharge Planning: 1-855-776-9464

MEMBER INFORMATION					
Last Name		First Name, Middle Initial		Date of Birth	
Phone Number		WellCare ID Number		Gender	☐ Male ☐ Female
Third-Party Insurance	☐ Yes ☐ No	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		Languages Spoken	

ORDERING PHYSICIAN/PRACTITIONER INFORMATION					
Last Name		First Name		NPI Number	
WellCare ID Number		Type	☐ PCP ☐ Specialist	Specialty	
Participating	☐ Yes ☐ No	Phone Number		Fax Number	
Street Address		City, State		ZIP	
Name of Requestor		Office Contact (if Different)			

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		First Name		NPI Number	
WellCare ID Number		Participating	☐ Yes ☐ No	Discipline/Specialty	
Street Address		City, State		ZIP	
Phone Number		Fax Number		Office Contact	

FACILITY/AGENCY INFORMATION					
Name		Facility ID		NPI Number	
Street Address		City, State		ZIP	
Phone Number		Fax Number		Office Contact	

Service Type Requested	List REV/CPT/HCPCS Code(s) and Number of Each Requested
Initial Inpatient ECT	
Concurrent Inpatient ECT	
Initial Outpatient ECT	
Ongoing Maintenance ECT	
Service Request Start Date:	

Diagnosis – Code and Description	
Indicate any change in diagnostic presentation	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

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REQUEST SPECIFICATION AND CLEARANCE			
ECT in past 6 months?	☐ Yes ☐No	**Number of previous sessions overall?**	
ECT used in the past?	☐Yes ☐No		
What was the treatment outcome of past ECT?			
Include all supporting documentation for ECT clearance requirements below: **(Failure to submit may delay processing of your request)**			

Date of second opinion by Board Certified Psychiatrist and MD Name:	**Date of Pre-ECT Lab Work:**	**Date of EKG:**	**Date of Anesthesiologist Clearance:**	**Date of Medical MD/Assessment Clearance:**

Any Labs not WNL? Explain.
Additional Documentation: **Psychiatric Evaluation (to include member's psychiatric history to determine indication for ECT)** **Informed Consent**
Any additional clearance needed/provided? Explain.

CLINICAL RATIONALE
Is ECT being performed for outpatient maintenance? If so, describe where and how the member will be safely monitored after treatment.
What courses of medication have been tried and failed prior to requesting ECT? (List at least 2.) And over what period of time?
Provide a thorough overview of all medical conditions – medications that had positive reaction (medication name; dates; symptom improvement)
Provide a thorough explanation of why ECT is the best course of treatment for this member at this time.

CURRENT MEDICATIONS (Psychotropic and Medical)			
Medication	**Dosage**	**Frequency**	**Adherent?**
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
Any medication contraindications? If yes, describe.			