

# Behavioral Health Service Request Form

## Electroconvulsive Therapy Services as Covered

<b>Please Submit to the Dedicated Fax Line Below</b>
<b>Georgia Medicare</b>
<b>Medicare Only Members: 1-877-892-8213</b>
<b>Dual Eligible Members (Members with Medicare &amp; Medicaid Policies): 1-855-292-0233</b>
<b>Discharge Planning: 1-855-776-9464</b>

MEMBER INFORMATION				
Last Name		First Name, Middle Initial		Date of Birth
Phone Number		WellCare ID Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Third-Party Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist	Specialty
Participating	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of previous sessions overall?		
ECT used in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
What was the treatment outcome of past ECT?				
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.				
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.				
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?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any medication contraindications? If yes, describe.				