

Behavioral Health Service Request Form



Electroconvulsive therapy (ECT)

Medicare			
Please submit to the dedicated fax line below.			
Florida: 1-855-710-0168		Kentucky: 1-888-365-5676	
Hawaii: 1-888-881-8225		New York: 1-855-713-0589	
Connecticut, Maine, North Carolina: 1-888-365-5607		Texas: 1-855-671-0259	
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: 1-855-710-0160			
Illinois, Michigan, Missouri, Washington: 1-855-713-0593			
Georgia: Medicare Only Members 1-877-892-8213 , Dual Eligible Members 1-855-292-0233			
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:

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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:

Request Specification and Clearance

ECT used in the past? Yes No ECT in past 6 months? Yes No Number of previous sessions overall?

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:
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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.

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Clinical Rationale

Is ECT being performed for outpatient maintenance? Yes No
If yes, 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.) Over what period of time?

Provide a thorough overview of all medical conditions. List medications that had a 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?
			<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

Are there any medication contraindications? Yes No
If yes, please describe: