



## Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered

Please Submit to the Dedicated Fax Line Below

**Medicaid**

**Kentucky – 877-544-2007**

### 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 Problems	

### REQUEST SPECIFICATION AND CLEARANCE

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### Electroconvulsive Therapy Services as Covered

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.				
<b>CLINICAL RATIONALE</b>				
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.				
<b>CURRENT MEDICATIONS (Psychotropic and Medical)</b>				
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.				