Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered

<Please Submit to the Dedicated Contract Fax Line Below>

Medicare			Medicaid
Arizona- 888-834-8404	**Kentucky-**888-365-5676	**Ohio-** 855-710-0164	**Georgia-** 888-871-0590
Arkansas- 855-710-0160	**Louisiana-** 855-710-0160	**South Carolina -** 855-710-0160	**Kentucky-** 877-544-2007
Connecticut- 888-365-5607	**Mississippi** - 855-710-0160	**Tennessee -** 855-710-0160	**Illinois-** 855-713-0595
Florida- 855-710-0168	**Missouri-** 855-710-0162	**Texas-** 855-671-0259	**New Jersey-** 888-339-2677
Georgia-855-710-0166	**New Jersey-**888-339-2677		**New York-** 855-713-0591
Illinois-855-713-0593	**New York-** 855-713-0589		

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

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:	

DSM-IV DIAGNOSIS (AXIS I – V)

Indicate any change in diagnostic presentation

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	

WellCare Health Plans

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Medical Problems			
Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	

REQUEST SPECIFICATION AND CLEARANCE			
ECT in last 6 months?	☐ Yes ☐ No	**Number of previous sessions overall?**	
ECT used in the past?	☐ Yes ☐ 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? And over what period of time; prior to requesting ECT? (List at least 2)
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?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe.			