

# Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered

Please Submit to the Dedicated Fax Line Below

## Medicare

Arizona 1-888-834-8404	Kentucky 1-888-365-5676
Florida 1-855-710-0168	New Jersey 1-888-339-2677
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, Indiana, Missouri, New Hampshire, Washington: 1-855-713-0593	

## 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	

## Behavioral Health Service Request Form

### Electroconvulsive Therapy Services as Covered

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.				