WellCare Health Plans

We're in this together: *Quality Health Care*

Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered

Please Submit to the Dedicated Contract Fax Line Below

Medicaid
Georgia 1-888-871-0590

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:	

DIAGNOSIS – Code and Description			
Indicate any change in diagnostic presentation			
Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
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?			

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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 within normal limits 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.			

Georgia Families® Choices for a Healthy Life

PeachCare for Kids®

Planning for Healthy Babies®

WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids®* members enrolled in the *Georgia Families®* program and women enrolled in the *Planning for Healthy Babies®* program.