



Behavioral Health Service Request Form

Electroconvulsive Therapy Services as Covered
Please Submit to the Dedicated Fax Line Below

Medicaid
New York – 855-713-0591

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
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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
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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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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
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any medication contraindications? If yes, describe.			