Healthy Blue

Electroconvulsive Therapy Prior Authorization Request

To request electroconvulsive therapy (ECT) services, please submit this form electronically using our preferred method at **https://www.availity.com*** or via fax to **1-844-462-0026**.

Member information					
Name					
Member number		Date of birth			
Address					
City, State		ZIP code			
Provider information					
Facility name		Facility NPI			
UM rep. contact		Phone		Fax	
Discharge planner name		Phone		Fax	
Attending provider name		Attending provider NPI #			
Facility status ☐ Participating provider ☐ Nonparticipating provider		Stage of treatment ☐ Initial ECT series ☐ Continuation of treatment		Location of treatment ☐ Inpatient ECT ☐ Outpatient ECT	
Facility TIN		Dates of service		Number of treatment(s)	
Medical clearance for ECT treatment					
Provider name		Date assessment completed			
Medical clearance			☐ Inpatient ☐ Outpatient		
Second opinion			☐ Inpatient ☐ Outpatient		

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

https://provider.healthybluemo.com

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Diagnoses (Include all behavioral health and physical health.)		

Reason member was referred for ECT

Current risk factors				
Suicide				
☐ None	☐ Ideation	☐ Intent without means	☐ Intent with means	☐ Contracted not to harm self
Homicide				
☐ None	☐ Ideation	☐ Intent without means	☐ Intent with means	☐ Contracted not to harm others

Abuse	
Physical or sexual abuse or child/elder neglect: ☐ Yes ☐ No	
If yes, patient is:	☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family
Abuse has been legally reported	☐ Yes ☐ No
Abuse or neglect involves a child or elder	☐ Yes ☐ No

Explain any significant history of suicidal, homicidal, impulse control or other behavior that may impact the patient's level of functioning.
Current mental status exam
Substance use assessment

Treatment history		
Current treatment team	**Name**	**Phone**
PCP		
Psychiatrist		
Anesthesiologist		
Psychologist		
ARNP		
Social worker		
Other		

History of inpatient treatment
Treatment compliance
Social support (Who will care for patient following treatment?)

Medication information		
Current medications (Include behavioral and physical health medications or submit a medication administration record.)		
Drug	Dose	Frequency
History of medications tried in the past and results		

Does patient have a history of poor response to several trials of antidepressants in adequate doses for a sufficient time?	☐ Yes ☐ No If yes, provide details:

Does patient have a history of a good response to ECT during an earlier episode of illness?	☐ Yes ☐ No If yes, provide details:
Does patient have a history of adverse effects with medication that are deemed to be less likely and/or severe with ECT?	☐ Yes ☐ No If yes, provide details:

Recent ECT treatment record (for continued care review)

Date	Provider name	Pretreatment score (for example, QUID, PHQ-9, etc.)	Unilateral/ bilateral	Seizure duration	Response

Provider signature:	Date:
Phone:	Fax:

Disclaimer: Authorization indicates that MCG Care Guidelines medical necessity guidelines have been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.