Healthy Blue

Dual Advantage

Electroconvulsive Therapy Prior Authorization Request

To request electroconvulsive therapy (ECT) services, please submit this form electronically at **https://www.availity.com*** or via fax to **844-430-1702**.

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:	Number of treatment(s):	
Dates of service:		

Medical clearance for ECT treatment	
Provider name:	Date assessment completed:

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

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Medical clearance:	☐ Inpatient ☐ Outpatient
Second opinion:	☐ Inpatient ☐ Outpatient

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 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.

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at **800-499-9554**.

Providers: You are required to return, destroy, or further protect any PHI you receive pertaining to patients that you are not treating. You are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.