SUBMIT TO
Utilization Management Department
Phone: 1-855-766-1497 Fax: 1-877.-725-7751

allwell. FROM absolute total care

ELECTROCONVULSIVE THERAPY (ECT) AUTORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Patient ID: _____

Last Auth #: _____

PREVIOUS BH/SUD TREATMENT

☐ None or ☐ OP ☐ MH ☐ SUD and/or ☐ IP ☐ MH ☐ SUD

List names and dates, include hospitalizations: _____

_____

Substance Abuse ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency, and last used: _____

_____

CURRENT ICD DIAGNOSIS

Primary: _____

R/O: _____ R/O: _____

Secondary: _____

Teritary: _____

Additional: _____

Additional: _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/Violent Behavior	☐	☐	☐	☐	☐
Psychotic Symptoms	☐	☐	☐	☐	☐

*3, 4, or 5 please describe what safety precautions are in place

_____

_____

PROVIDER INFORMATION

Provider Name (print): _____

Hospital where ECT will be performed: _____

Professional Credential: ☐ MD ☐ PhD ☐ Other _____

Physical Address: _____

Phone #: _____ Fax #: _____

TPI/NPI #: _____

Tax ID #: _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested: _____

Type Bilateral: _____ Unilateral: _____

Frequency: _____

Date first ECT: _____ Date last ECT: _____

Est. # of ECTs to complete treatment: _____

Requested start date for authorization: _____

Length: _____ Length of convulsion: _____

Has information been shared with the PCP regarding behavioral health provider contact information, date of initial visit, presenting problem, diagnosis, and medications prescribed (if applicable)?

PCP communication completed via: ☐ Phone ☐ Fax ☐ Mail

Member refused by: _____

Coordination of care with other behavioral health providers? _____

Has informed consent been obtained from patient/guardian? _____

Date of most recent psychiatric evaluation: _____

Date of most recent physical examination and indication of an anesthesiology consult was completed: _____

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing: _____

_____

Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant: _____

_____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials): _____

_____

_____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments: _____

_____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment: _____

_____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occured: _____

_____

Please indicate the plans for treatment and medication once ECT is completed: _____

_____

STANDARD REVIEW:
Standard 14-day time frame will be applied.

_____
Clinician Signature Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life, or ability to regain maximum function.

_____
Clinician Signature Date

SUBMIT TO
Utilization Management Department
Phone: 1-855-766-1497 Fax: 1-877-725-7751