



OUTPATIENT BEHAVIORAL HEALTH Prior Authorization Fax Form **Electroconvulsive Therapy**

Complete and Fax to:
1-844-208-9113

This is a standard authorization request that may take up to 7 calendar days to process. **If this is an expedited request for MMA, HK, CW or Medicare, please contact us at 1-844-477-8313. For an expedited request for Ambetter members, please call 1-877-687-1169.**

Request for additional units. Existing Authorization Units

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID/Medicaid ID * Date of Birth *
(MMDDYYYY)
Last Name, First

Medication (Psychotropic) Medication

Medication **Amount** **Frequency**

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:

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

Please objectively define when ECTs will be discontinued—what changes will have occurred:

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

Doctor signature and date

(MMDDYYYY)

**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.**

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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