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

sunshine health

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 *

Last Name, First

Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION Requesting

NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ ***Same as Requesting Provider***

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Number of sessions requested

Number of sessions completed

Type _____

Date of first ECT:

Frequency:

Est. # of ECTs to complete treatment:

Date of most recent psychiatric evaluation:

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

if other, please specify:

Last ECT info:

Length:

Length of convulsion:

Treatment goals/progress

Past medical problems:

Presenting problem:

Clearly describe any risk of out of home placement and/or risk of higher level of care:

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.

Rev. 8 25 2016
FL-PAF-0675

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MEMBER INFORMATION

Member ID/Medicaid ID *

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Last Name, First

Date of Birth *
☐☐☐☐☐☐☐☐
(MMDDYYYY)

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)

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