



# 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 \*  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 \*   Additional Procedure Code   Start Date OR Admission Date \*  Diagnosis Code \*   
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  
Additional Procedure Code   Additional Procedure Code   End Date OR Discharge Date  Number of sessions requested  Number of sessions completed   
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)

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:  Treatment goals/progress   
Length:  Length of convulsion:  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.**



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(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)

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**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.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.