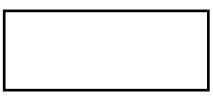

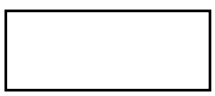

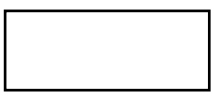

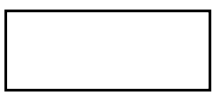

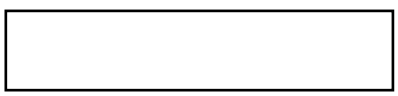

sunshine health

# 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)

### 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.***





Rev. 8 25 2016
**FL-PAF-0675**