ECT Prior Authorization Request Form

Date of Request: Total Number of pages

PLEASE NOTE: Processing time for a Standard Request for Authorization is 14 calendar days.

If the member's life or health is in serious jeopardy, please submit an Urgent Request by phone for optimal processing times. Call us at 1-800-564-5465

Member Information

Name: Member ID #: Date of Birth:

Other Insurance

☐Yes ☐No If yes, please specify:

Phone #:

Title XIX/XXI ☐Y ☐N SMI ☐Y ☐N

Requesting Provider Information

Requesting Physician Name: TIN/NPI#:

Address: Phone #:

Completed By:

TO BE COMPLETED BY PRESCRIBING CLINICIAN REQUESTING THE ECT TREATMENT

1) **Current DIAGNOSES per DSM-V:**

2) **Treatment History** Past ECT Treatment (CHECK one)? ☐N ☐Y

If Yes, provide dates, location, # of treatments and results:

Current psychiatric medications including Dosages and Duration:

a. Medication History: **Trials of antidepressants and augmentation strategies tried:**

Medication	Dose Achieved	Duration	Results	Side Effects	Reason D/C

a. **Target Symptoms**:

b. **What will determine # of Treatments? (Success or Failure, Outcomes Measure):**

c. **Unavoidable adverse effects** which are less likely or severe with ECT therapy:

d. **Need for rapid definitive response** on physical or psychiatric grounds:

e. **Additional information/consideration**:

1) SUBSTANCE ABUSE HISTORY – History and Current Status:

2) **MEDICAL HISTORY**:

Current Physical Health Care Providers:

1. PCP:	Name:	Phone:	
2. Specialist:	Name:	Phone:	Specialty:
3. Specialist:	Name:	Phone:	Specialty:

Known Medication Allergies:

Current Non-Psychiatric Medications:

Pregnancy Status:

Known Medical Conditions:

Known Seizure History:

Known Contraindications To ECT:

Known Reactions to Anesthesia, or Medical Complications to ECT:

Labs/Diagnostic tests currently available to prescribing clinician (*forward copies of most recent test with this request*):

Name of Doctor Completing ECT:
Place of Service (Check one): ☐ **Outpatient or** ☐ **Inpatient - If Inpatient, why?**

Name of Anesthesiologist:

IMPORTANT*: *Failure to provide complete documentation specific to the request will result in delayed processing times

When completed, please fax this form to our Prior Authorization Department at 1-800-217-9345.

Authorization does not guarantee payment. All authorizations are subject to member eligibility on the date of service. If member is determined ineligible, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on the date of service. Verify benefit coverage in the member handbook located @ http://www.mercycareplan.com/members/mcp/information.