Electroconvulsive Therapy (ECT) Request Form

Submit via fax to Magellan at 1-888-656-0259 (Pennsylvania) or 1-888-656-3510 (California)

Magellan HEALTHCARE

Date of Request: _____ Initial: ☐ Concurrent: ☐

Member Information

Member Name:_____ DOB:_____ Member ID: _____

Subscriber Name:_____ Subscriber ID:_____ Group #: _____

Provider Information

Facility/Provider Name:_____ NPI #: _____

Address:_____ Phone #:_____

Tax ID#:_____ Fax #: _____

Name/Credentials of Medical Practitioner Performing ECT: _____

ECT History

Past ECT? Yes ☐ No ☐ If yes, was ECT within past 6 months? Yes ☐ No ☐

Date(s) of Past ECT:_____ N/A ☐ Frequency of Past ECT:_____ N/A ☐

Authorization Request for ECT

Type of ECT: Unilateral ☐ Bilateral ☐ CPT Code:_____ Planned ECT Frequency: _____

Start Date:_____ Planned ECT End Date:_____ Total Sessions Requested:_____

Response to Most Recent ECT Session: Length:_____ Length of Convulsion:_____

☐ Member has undergone medical review and clearance.

Rationale for Selecting ECT

☐ Catatonia
☐ Extension of acute treatment
☐ Inadequate response to pharmacotherapy despite adequate duration and dosage, documented adherence and trials from two or more classes of medication
☐ Maintenance treatment
☐ Neuroleptic malignant syndrome
☐ Nutritional compromise
☐ Pharmacotherapy not preferred due to risk of adverse effects
☐ Suicidality
☐ Treatment resistant depression
☐ Treatment resistant mania
☐ Treatment resistant psychosis

Current Diagnoses

ICD-10 Code: _____ Description: _____

ICD-10 Code: _____ Description: _____

ICD-10 Code: _____ Description: _____

Behavioral Health Treatment History

Level(s) of Care (select all that apply): Inpatient ☐ RTC ☐ PHP ☐ IOP ☐ OP ☐ # Inpatient Admissions:_____

Current/Most Recent Behavioral Health Treatment

Level of Care:_____ Dates of Service: _____

Current Medications/Dosage

Provider Name/Title (print): _____

Provider Signature:_____ Date:_____