Behavioral Health Service Request Form

Electroconvulsive therapy (ECT)

Medicare

Please submit to the dedicated fax line below.	
Arizona: **1-855-713-0593**	Kentucky: **1-888-365-5676**
Florida: **1-855-710-0168**	New Jersey: **1-888-339-2677**
Hawaii: **1-888-881-8225**	New York: **1-855-713-0589**
Connecticut, Maine, North Carolina: **1-888-365-5607**	Texas: **1-855-671-0259**
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: **1-855-710-0160**	
Illinois, Iowa, Michigan, Missouri, Washington: **1-855-713-0593**	
Georgia: Medicare Only Members **1-877-892-8213**, Dual Eligible Members **1-855-292-0233**	

Member Information

Last Name:	First Name, Middle Initial:	Date of Birth:
Phone Number:	Wellcare ID Number:	Gender: ☐ Male ☐ Female

Third-Party Insurance: ☐ Yes ☐ No	If yes, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.	Languages Spoken:

Ordering Physician/Practitioner Information

Last Name:	First Name:		NPI Number:
Wellcare ID Number:	Type:	☐ PCP ☐ Specialist	Specialty:
Participating: ☐ Yes ☐ No	Phone Number:		Fax Number:
Street Address:	City, State:		ZIP:
Name of Requestor:	Office Contact (if different):		

Treating Provider/Practitioner Information

Last Name:	First Name:	NPI Number:
Wellcare ID Number:	Participating: ☐ Yes ☐ No	Discipline/Specialty:
Street Address:	City, State:	ZIP:
Phone Number:	Fax Number:	Office Contact:

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Facility/Agency Information

Name:	Facility ID:	NPI Number:
Street Address:	City, State:	ZIP:
Phone Number:	Fax Number:	Office Contact:

Service Type Requested	List REV/CPT/HCPCS Code(s) and Number of Each Requested
Initial Inpatient ECT	
Concurrent Inpatient ECT	
Initial Outpatient ECT	
Ongoing Maintenance ECT	
Service Request Start Date:	

Diagnosis – Code and Description

Indicate any change in diagnostic presentation

Primary Diagnosis:

Secondary Diagnosis:

Medical Diagnoses:

Request Specification and Clearance

ECT used in the past? ☐ Yes ☐ No	ECT in past 6 months? ☐ Yes ☐ No	Number of previous sessions overall?

What was the treatment outcome of past ECT?

Include all supporting documentation for ECT clearance requirements below:
(Failure to submit may delay processing of your request)

Date of second opinion by Board-certified Psychiatrist and MD Name:	Date of Pre-ECT Lab Work:	Date of EKG:	Date of Anesthesiologist Clearance:	Date of Medical MD/ Assessment Clearance:

Any Labs not WNL? Explain.

Additional Documentation:
- Psychiatric Evaluation (to include member's psychiatric history to determine indication for ECT)
- Informed Consent

Any additional clearance needed/provided? Explain.

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Clinical Rationale

Is ECT being performed for outpatient maintenance? ☐ Yes ☐ No
If yes, describe where and how the member will be safely monitored after treatment.

What courses of medication have been tried and failed prior to requesting ECT? (List at least 2.) Over what period of time?

Provide a thorough overview of all medical conditions. List medications that had a positive reaction (medication name; dates; symptom improvement)

Provide a thorough explanation of why ECT is the best course of treatment for this member at this time.

Current Medications (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are there any medication contraindications? ☐ Yes ☐ No
If yes, please describe: