



## REQUEST FOR INITIAL OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT)

**Form only applies to initial outpatient ECT treatment.**

**General Instructions:**

- Type or print neatly in the designated fields.
- Complete all applicable fields.
- Write the numerical diagnosis code(s) from the DSM-5 or ICD-10.

**Authorization is not required for:**

- BCBS Alabama
- BCBS Kansas
- BCBS Arkansas

**Return via fax to the appropriate fax number:**

- Lucet Employee: 816-416-7788  
If your client is covered as an employee of Lucet or a spouse or dependent of a Lucet employee, please return by fax to our Internal Behavior Health Benefit Review team.
- 816-237-2364
  - BCBS Florida (Florida Blue)
  - BCBS Kansas City (Blue KC)
  - BCBS Louisiana
  - Walmart
  - SCAN

Note: For verification of benefits, eligibility, authorization requirements, and allowable codes, please call the customer service number listed on the member's insurance ID card.

**Medical policy information is available at [Lucethealth.com](http://Lucethealth.com) under Medical Necessity Criteria.**



## INITIAL OUTPATIENT ECT TREATMENT REQUEST FORM

### Member's Information

Name: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Requesting Physician's Information

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address where services are being rendered: \_\_\_\_\_

Tax ID#: \_\_\_\_\_ NPI#: \_\_\_\_\_

### Facility's Information

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address where services are being rendered: \_\_\_\_\_

Tax ID#: \_\_\_\_\_ NPI#: \_\_\_\_\_

### Utilization Reviewer Contact Information

Name: \_\_\_\_\_

Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

### ECT Information

ECT Start Date: \_\_\_\_\_

Primary diagnoses (the primary focus of ECT treatment):

- Major Depressive Disorder: single or recurrent; severe, psychotic or non-psychotic  
DSM-5 Code: \_\_\_\_\_
- Bipolar Disorder: depressed, mixed, or manic  
DSM-5 Code: \_\_\_\_\_
- Schizophrenia / Schizophrenia Spectrum / Schizoaffective / Psychotic Disorders  
DSM-5 Code: \_\_\_\_\_
- Catatonia  
DSM-5 Code: \_\_\_\_\_
- Neuroleptic Malignant Syndrome  
ICD-10 Code: \_\_\_\_\_

Current episode duration (# months): \_\_\_\_\_



Check the applicable box(es) below to attest that at least one of the following criteria have been met:

- Two or more adequate trials of full dose antidepressants (adequate time = eight (8) weeks) have been tried.
- Augmentation with lithium, thyroid, or atypical antipsychotics has been tried or considered.
- Member's inability to tolerate medication due to severe or intolerable side effects.
- The member is markedly impaired by his/her psychiatric illness, so serious physiological or physical complications are very likely.
- History of a significant positive prior response to ECT.

Current symptoms or other relevant clinical information:

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**For ECT request found to be medically necessary, the following CPT codes and units will include, as applicable:**

00901 – Electroconvulsive Therapy Facility (Facility)

90870 – Electroconvulsive Therapy Treatment and Monitoring (Psychiatrist)

ECT Initial: 12 units / 8 weeks

**Medical policy information is available at [Lucethealth.com](http://Lucethealth.com) under Medical Necessity Criteria.**

This form needs to be completed in its entirety. If there is a section that is not applicable it needs to be marked as such to ensure timely processing once received.