REQUEST FOR INITIAL OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT)

Form only applies to initial outpatient ECT treatment.

General Instructions:

- All Member information (Member's Name, Date of Birth, Insurance ID Number, Member's Phone Number) must be completed, or form will be returned.
- 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 (Except Lowe's)
- BCBS Arkansas (Except for FEP)
- BCBS Kansas
- Walmart

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 Alabama (Lowe's)
  - BCBS Arkansas (FEP)
  - BCBS Florida (Florida Blue)
  - BCBS Kansas City (Blue KC)
  - BCBS Louisiana
  - Imperial
  - 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 under Medical Necessity Criteria.

INITIAL OUTPATIENT ECT TREATMENT REQUEST FORM

Member's Information
Name: ____
Insurance Policy #: ____________________
Date of Birth: _______________ Phone #: _________________

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 tired.
- ☐ 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:

____
____
____

☐ PLEASE CHECK THIS BOX TO ATTEST TO THE FACT THAT ALL OF THE INFORMATION PROVIDED IS ACCURATE AND REFLECTED IN THE PATIENT'S MEDICAL RECORD.

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 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.