



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:

- 816-237-2364
 - BCBS Alabama (Lowe's)
 - BCBS Arkansas (FEP)
 - BCBS Florida (Florida Blue)
 - BCBS Kansas City (Blue KC)
 - BCBS Louisiana
 - Imperial
 - SCAN

For Lucet Employees Only: 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.

- Lucet Employee: 816-416-7788

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](https://www.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 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:

☐ **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](https://www.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.