REQUEST FOR CONTINUATION OR MAINTENANCE OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT)

Form only applies to continuation and maintenance outpatient ECT treatment.

General Instructions:

- Complete all required fields (indicated by an *).
- Type or print neatly in the designated fields.
- Write the numerical diagnosis code(s) from the DSM-5 or ICD-10.
- Incomplete forms cannot be processed.

Submitting TMS Form

WebPass: https://webpass.ndbh.com/
Fax: 816-237-2364 (All except Blue KC Lucet Employee Group)

F*or Lucet Employees Only:* *If your client is covered as a Lucet employee or a spouse or dependent of a Lucet employee (under Blue KC), please return by fax to 816-416-7788.*

Authorization is not required for:

- BCBS Alabama (Except Lowe's)
- BCBS Arkansas (Except for FEP)
- BCBS Kansas
- Walmart

Medical Policy information is available on the Lucet website at https:// lucethealth.com/providers/resources/mnc/.

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.

Version 10/2025 for 2026

CONTINUATION OR MAINTENANCE
OUTPATIENT ECT TREATMENT REQUEST FORM

Member's Information
Name:* _____
Insurance Policy #:* _____
Date of Birth:* _____ Phone #:* _____
Authorization #:* _____

Check the applicable box below to attest that the criteria have been met:*

☐	Continuation – Must meet all of the following: 1. The attending psychiatrist performs: i. An assessment of current symptoms and medications. ii. Determine the need for Continuation ECT. iii. Determine the timing and frequency of treatments. 2. The member has shown an adequate response to the initial episode of ECT. 3. The member expresses a preference to continuation ECT OR the member is intolerant to pharmacotherapy. 4. The member or guardian provides informed consent of Continuation ECT and is educated concerning the risks and benefits.
☐	Maintenance Must meet all of the following: 1. The attending psychiatrist performs: i. An assessment of current symptoms and medications. ii. Determine the need for Maintenance ECT. iii. Determine the timing and frequency of treatments. 2. The member has shown an adequate response to the continuation of ECT. 3. The member has a marked history of relapse and recurrence OR the member has a history of significant symptom increases when Continuation ECT was tapered. 4. The member expresses a preference for Maintenance ECT OR the member is intolerant to pharmacotherapy. 5. The member or guardian provides informed consent of Maintenance ECT and is educated concerning the risks and benefits.

☐ **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)
Continuation: 6 units / 6 months
Maintenance: 24 units / 1 year