YouthCare HealthChoice Illinois

SUBMIT TO
Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

DEMOGRAPHICS

Patient Name _____

DOB _____

SSN _____

Patient ID _____

Last Auth # _____

PREVIOUS BH/SUD TREATMENT

☐ None or ☐ OP ☐ MH ☐ SUD and/or ☐ IP ☐ MH ☐ SUD

List names and dates, include hospitalizations _____

_____

Substance Abuse ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency and last used _____

_____

CURRENT ICD DIAGNOSIS

Primary _____

R/O _____ R/O _____

Secondary _____

Teritary _____

Additional _____

Additional _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/ Violent Behavior	☐	☐	☐	☐	☐
Psychotic Symptoms	☐	☐	☐	☐	☐

*3, 4, or 5 please describe what safety precautions are in place

_____

_____

PROVIDER INFORMATION

Provider Name (print) _____

Professional Credential: MD PhD Other _____

Provider TPI/NPI # _____

Provider Tax ID # _____

Hospital where ECT will be performed _____

Physical Address _____

Phone _____ Fax _____

Hospital TPI/NPI # _____

Hospital Tax ID # _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested _____

Type Bilateral _____ Unilateral _____

Frequency _____

Date first ECT _____ Date last ECT _____

Est. # of ECTs to complete treatment _____

Requested start date for authorization _____

LAST ECT INFO

Length _____ Length of convulsion _____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

PCP communication completed on via: ☐ Phone ☐ Fax ☐ Mail

Member Refused By _____

Coordination of care with other behavioral health providers? _____

Has informed consent been obtained from patient/guardian? _____

Date of most recent psychiatric evaluation _____

Date of most recent physical examination and indication of an anesthesiology consult was completed _____

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing _____

_____

Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant _____

_____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials) _____

_____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments

_____

_____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment _____

_____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occured _____

_____

Please indicate the plans for treatment and medication once ECT is completed _____

_____

STANDARD REVIEW:
Standard 14-day time frame will be applied.

_____
Clinician Signature Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

_____
Clinician Signature Date

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