



## Electroconvulsive Therapy Services: Supplemental Information

Please provide the following supporting information when requesting Medical Necessity Determination (MND) review of Outpatient Electroconvulsive Therapy (ECT) services that are to be provided to a member.

Please include separate sheet(s) if there is not sufficient room for your responses. Completed information may be included as attachments to the request you submit through our Utilization Management Request Tool, accessible via [NaviNet](#).

### Member Information

Member Name \_\_\_\_\_

Member Date of Birth \_\_\_\_\_

Subscriber ID Number \_\_\_\_\_

### Provider Information

Practitioner Name \_\_\_\_\_

Practitioner Type 1 NPI \_\_\_\_\_

Group/Facility Name \_\_\_\_\_

Group/Facility TIN or Medicare Number \_\_\_\_\_

Group/Facility Address \_\_\_\_\_

Requestor Name \_\_\_\_\_

Requestor Phone \_\_\_\_\_

### Present Illness Information

ICD10 and Diagnosis Codes (include all psychiatric, substance use & medical diagnosis codes, as appropriate)

\_\_\_\_\_

Symptoms

\_\_\_\_\_

Assessment Scales (include Assessment Scale name and member score)

\_\_\_\_\_

Current Medications/Dosage

\_\_\_\_\_

Other Treatments (if applicable)

\_\_\_\_\_

## Prior Treatment History

High Level of Care Admissions (type of admission and dates)

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Prior Medication Trials (include medication name, dosage and dates)

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Prior ECT or TMS Services Received (include type of service and dates)

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Prior Psychotherapy (if applicable)

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## Treatment Plan

Requested Start Date of Service \_\_\_\_\_

Requested End Date of Service \_\_\_\_\_

Treatment Frequency and Duration \_\_\_\_\_

Additional Treatment in Conjunction with ECT (if applicable)

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## Plan of Care

Concurrent Review (please indicate member progress)

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Discharge Plan

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