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)

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

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

Prior Psychotherapy (if applicable)

Treatment Plan

Requested Start Date of Service _____

Requested End Date of Service _____

Treatment Frequency and Duration _____

Additional Treatment in Conjunction with ECT (if applicable)

Plan of Care

Concurrent Review (please indicate member progress)

Discharge Plan
