BlueCross BlueShield of North Carolina

Use for Commercial and SHP Members
Fax: 866-987-4161

Electroconvulsive Therapy
AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval. Incomplete forms may delay processing. All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth

Requesting/Ordering Provider Information		Servicing Provider or Facility Location (for services to be performed outside of the provider's office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #		**Fax #**	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____

Authorization Request type (check one)	☐ **Initial Request** ☐ **Extension Request and previous reference/authorization #** _	**Place of Service (check one)**	☐ **Outpatient Hospital** ☐ **Inpatient Hospital** ☐ **Other** _____
Requested ECT Start Date		**Expected End Date**	
CPT (Procedure Code)	☐ **90870 and # Units** _____ ☐ **Other** _____	**Is this a transition after IP ECT?**	☐ Yes ☐ No
Current Medication (Dosages, duration)			
Current Psychological Therapy (type, frequency, duration)			

Electroconvulsive Therapy - ECT

Patient Name	Blue Cross NC Patient ID number	Patient Date of Birth

Prior ECT Treatment(s) and Response

Please List Dates and Response to Treatment

Dates of Treatment	Response to Treatment

Other Treatment History

Please provide details related to prior treatment history and response, including service category type (i.e. Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy).

☐ Please indicate if including as a separate attachment if necessary.

Service Category	Dates	Reason for Admission	Response

Please list psychopharmacologic agents that member has been prescribed and trialed.

Drug	Drug Class	Length of Trial/Start and End Dates	Max Dose	Member Response

Diagnosis/Condition Amenable to ECT

Include description of severity/acuity

Electroconvulsive Therapy - ECT

Patient Name	Blue Cross NC Patient ID number	Patient Date of Birth

Clinical symptoms necessitating need for ECT, including those related to inadequate pharmacotherapy	**Clinical Symptoms related to underlying mental health disorder that require treatment with ECT (ex. catatonia, neuroleptic malignant syndrome, markers of mental health severity/acuity, etc.) Please include standardized suicide risk assessments and rating scales:** **This patient has received a comprehensive medical examination to rule-out or address contraindications to ECT. ☐ YES ☐ NO**
For EXTENSION of acute or maintenance treatment ONLY:	**Response to acute treatment** **Goal/Rational of continued treatment:** **Maintenance Treatment Rationale:**

By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature:_____Date: _____

Fax this form with required documentation to Blue Cross NC Commercial Behavioral Health @866-987-4161.

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