WellCare Health Plans

Behavioral Health Service Request Form

Covered Electroconvulsive Therapy Services
Please submit to the WellCare Advocate Complete FIDA (Medicare-Medicaid Plan)
dedicated fax line: 1-855-550-8977

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan 14 days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

MEMBER INFORMATION

Last Name:		**First Name, Middle Initial:**		**Date of Birth:**	
Phone:		**Member ID:**		**Gender:**	☐ Male ☐ Female
Third Party Insurance:	☐ Yes ☐ No	If **yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		**Languages Spoken:**	

ORDERING PROVIDER/PRACTITIONER INFORMATION

Last Name:		**First Name:**		**NPI Number:**	
Provider ID:		**Type:**	☐ PCP ☐ Specialist	**Specialty:**	
Participating:	☐ Yes ☐ No	**Phone:**		**Fax:**	
Address:		**City and State:**		**ZIP:**	
Requestor Name:		**Office Contact (if different):**			

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name:		**First Name:**		**NPI Number:**	
Provider ID:		**Participating:**	☐ Yes ☐ No	**Discipline/Specialty:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

FACILITY/AGENCY INFORMATION

Name:		**Facility ID:**		**NPI Number:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

SERVICE TYPE REQUESTED	LIST REV/CPT/HCPCS CODE(S) AND NUMBER OF EACH REQUESTED
Initial Inpatient ECT:	
Concurrent Inpatient ECT:	
Initial Outpatient ECT:	
Ongoing Maintenance ECT:	
Requested Start Date:	

DSM-IV DIAGNOSIS (AXIS I–V)

Indicate any change in diagnostic presentation:

Primary Diagnoses:		**R/O:**	
Secondary Diagnoses:		**R/O:**	
Medical Problems:			

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Current GAF/CAFAS:		**Highest GAF/CAFAS in the Past Year:**	

REQUEST SPECIFICATION AND CLEARANCE

ECT in the last 6 months?	☐ Yes ☐ No	**Number of previous sessions overall:**
ECT used in the past?	☐ Yes ☐ No	

What was the treatment outcome of the past ECT:

Name and Date of the Second Opinion by a Board Certified Psychiatrist and MD:	**Date of Pre-ECT Lab Work:**	**Date of EKG:**	**Date of Anesthesiologist Clearance:**	**Date of Medical MD/Assessment Clearance:**

Any labs not WNL? If yes, describe:

Any additional clearance needed/provided? If yes, describe:

CLINICAL RATIONALE

Is ECT being performed for outpatient maintenance? If so describe where and how the member will be safely monitored after treatment:

What courses of medication have been tried and failed? Over what period of time, prior to requesting ECT (list at least 2):

Provide a thorough overview of all medical conditions:

Provide a thorough explanation of why ECT is the best course of treatment for this member at this time:

CURRENT MEDICATIONS (PSYCHOTROPIC AND MEDICAL)

Medication:	Dosage:	Frequency:	Adherent:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Any medication contraindications? If yes, describe: