SUBMIT TO
Utilization Management Department
PHONE 1-866-595-8133 | FAX 1-888-725-0101

louisiana healthcare connections™

ELECTROCONVULSIVE THERAPY (ECT)

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

DEMOGRAPHICS

Patient Name _____

DOB _____

Medicaid ID #_____

Last Auth #_____

PREVIOUS BH/SA TREATMENT

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

List names and dates, include hospitalizations _____

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

Tobacco Use ☐ None ☐ By History and/or ☐ Current/Active

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

_____

Current ICD Diagnosis

Primary (Required): _____

Secondary _____

Tertiary _____

Additional_____

Additional_____

If the Member has a substance use and /or HIV diagnosis, has a consent to release information for these related conditions been obtained? ☐Yes ☐No ☐ N/A

Primary Care Provider (PCP) Communication

Has information been shared with the PCP regarding:

The initial evaluation & treatment plan? ☐Yes ☐ No

This updated evaluation & treatment plan? ☐ Yes ☐ No

PCP Name/Date last notified:_____

If No, explain_____

PROVIDER INFORMATION

Provider Name(print) _____

Professional Credential: ☐ MD ☐ PhD ☐ Other _____

Physical Address _____
(street address, city, state, zip code)

Phone _____ Fax _____

TPI/NPI #_____

Tax ID #_____

Please indicate to whom the authorization should be made

Individual Provider ☐ Yes ☐ No Group / Facility ☐ Yes ☐ No

CURRENT RISK/LETHALITY

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

*2 - 5 please describe what safety precautions are in place

_____

_____

Please answer YES or NO to the following questions

Is Member currently participating in any community based support groups / interventions? ☐Yes ☐ No ☐

Are the Member's family/supports involved in treatment? ☐Yes ☐ No

Coordination of care with other behavioral health providers?

☐Yes ☐No

Coordination of care with medical providers? ☐Yes ☐No

Has Member been evaluated by a Psychiatrist? ☐ Yes ☐No

Is this Member currently receiving 1915(i) SPA, 1915(c), or 1915(b)(3) waiver services ? ☐ Yes ☐ No

(If yes, please describe)? _____

TREATMENT GOALS

List primary complaint / problem to be addressed _____

List measureable treatment goals_____

DISCHARGE GOALS

Objectively describe how you will know the patient is ready to discontinue treatment: _____

_____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW *	3 MOD*	4 HIGH*	5 EXTREME*
Overall progress toward goal	☐	☐	☐	☐	☐
Compliance with treatment	☐	☐	☐	☐	☐

Medical Psychiatric Eval done? (even if PCP providing meds) ☐ Yes ☐ No

Medication given by? ☐ Psychiatrist ☐ PCP ☐ N/A

REQUESTED AUTHORIZATION

☐ 90870 ECT Single Requires Authorization for Par and Non Par Providers

☐ 901 Psychiatric / Psychological Treatment: Electroshock Treatment

Total sessions requested_____ Frequency of visits_____ CPT Codes_____

Estimated # of sessions to complete treatment episode_____ Requested Start Date _____

Clinician Name	Clinician Signature	Date

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