**OP ECT (Outpatient Electroconvulsive Therapy) Request template/requirements (submitted by provider)**

**Scenario:** Completing a pre-authorization review for outpatient ECT

**Effective Date:** 12/1/2015

Please Email (preferred) OR Fax the completed form to the contact information below:

EMAIL: [la.beh.auths@uhc.com](mailto:la.beh.auths@uhc.com%20)

FAX #: **1-855-202-7023**

***NOTE: Requests should be typed and not handwritten***

**REQUEST**

* Member Name: Click here to enter text.
* Date of Birth: Click here to enter text.
* Medicaid ID Number: Click here to enter text.

**FACILITY INFORMATION**

* Level of Care (LOC) being requested: Click here to enter text.
* Provider/Facility Name: Click here to enter text.
* Facility Address: Click here to enter text.
* Facility TIN: Click here to enter text.
* Facility Phone and Extension: Click here to enter text.
* Attending Physician: Click here to enter text.
* Attending Phone: Click here to enter text.
* UR Contact (phone and fax number Name of provider: Click here to enter text.

**AUTHORIZATION REQUEST**

* Current prescribed medication: Click here to enter text.
* Why now? : Click here to enter text.
* Document any history of failed medication trials (if none, please note that): Click here to enter text.
* Current treatment plan: Click here to enter text.
* Child/adolescent, pregnant, or presence of dementia? : Click here to enter text.
* Medically cleared? : Click here to enter text.
* Has a pre-ECT global cognitive baseline level of functioning been completed? : Click here to enter text.
* Has there been previous ECT treatment? If yes, when? Was it successful? : Click here to enter text.
* What is the requested frequency and anticipated length of ECT? (6-12 is average for initial at 2-3x per week): Click here to enter text.

**c*ontinued…***

* When is the next scheduled ECT appointment? : Click here to enter text.
* Who will transport the member to and from treatments and monitor them immediately after? :

Click here to enter text.

**OP ECT Continuation and Maintenance (request for continued authorization)**

* Update any new medical conditions or complications from ECT: Click here to enter text.
* Has a post-ECT global cognitive baseline level of functioning been completed? : Click here to enter text.
* Current prescribed medications? : Click here to enter text.
* Progress addressing precipitant? (current symptoms): Click here to enter text.
* What is the frequency and anticipated length of ECT? (Usually 1x every 1-3 weeks, re-eval at 3 months): Click here to enter text.
* Who will transport member to and from and monitor them immediately after treatments? :

Click here to enter text.