BlueCross BlueShield of Illinois

Electroconvulsive Therapy (ECT)

ECT REQUEST FORM

Provider must call Blue Cross Community MMAI at 877-723-7702
Blue Cross Community Health Plans at 877-860-2837 to verify benefits.
After completing the form, fax it to 312-233-4099.

Date________________________

Check One: ☐ Initial Request ☐ Concurrent ☐ Discharge

Patient Name________________________ Date of Birth________________________

Subscriber Name________________________ Subscriber ID #________________ Group #________________

Facility/Provider Name ________________________ NPI#________________________

Address________________________ City________________ State________ Zip________

Primary MD Full Name ________________________ MD NPI#________________________

Address________________________ City________________ State________ Zip________

UR/Contact Name________________________ Phone #________________ Fax #________________

ECT History: Any Past ECT? ☐ Yes ☐ No ECT in the last 6 months? ☐ Yes ☐ No

Past Frequency?________________ (x per week/month) Brief Details of ECT to Date: ________________________

Is this a transition after IP ECT? ☐ Yes ☐ No

Current ECT Plan-Frequency:________________ (x per week/month) Visits Requested (CPT Code): ☐ 90870 #________

Requested ECT Auth Start Date: ________________________ Tentative end date of treatment:________________________

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: ________________ DX Name: ________________ Specifier:________________

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Medications ____

Current Clinical Presentation/Risk Factors (Substance abuse: Include last date of use) ________________________

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Previous MH/CD Treatment ____

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Current Treatment Goals ____

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Discharge Plan/Summary ____

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Additional clinical information can be faxed with this form if needed.

My signature confirms that I am providing the requested services:

Signature____ Date________________