BlueCross BlueShield of Texas

Electroconvulsive Therapy (ECT)
ECT REQUEST FORM

The provider must call BCBSTX at **1-866-355-5999** to check benefits.
For initial services, the provider can complete this form and submit it through Availity or fax the completed form to BCBSTX at **1-877-361-7646.**

Date_____

Check One: ☐ Initial Request ☐ Concurrent ☐ Discharge

Patient Name_____ Patient Date of Birth _____

Participant Name_____ **Participant** ID _____ Group # _____

Facility/Provider Name _____ NPI _____

Address _____ City _____ State ____ Zip _____

Primary MD Full Name _____ MD NPI _____

Address _____ City _____State_____ Zip_____

UR/Contact Name _____ Phone _____ Ext. _____ Fax _____

ECT History: Has patient had ECT in the past? ☐ Yes ☐ No Past Has patient had ECT in the last **six** months? ☐ Yes ☐ No

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 list ICD-10 code(s), Diagnosis **(DX)** Name, Specifier and all Medical Diagnoses.

ICD-10 Code_____ DX Name _____ Specifier _ _____

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ICD-10 Code_____ DX Name _____ Specifier _____

Medications (Dosages):

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

Previous MH/CD Treatment:

Current Treatment Goals:

Discharge Plan/Summary:

My signature confirms that I am providing the requested services:

Signature _____ Date _____

TECT