Aetna Better Health® of Illinois
3200 Highland Ave, MC F648
Downers Grove, IL 60515

Submit to Aetna Better Health UM
Phone:1-866-329-4701/Fax:1-844-528-3453

ELECTROCONVULSIVE THERAPY (ECT) AUTORIZATION REQUEST FORM

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

DEMOGRAPHICS

Patient Name_____

DOB_____

SSN _____

Patient ID _____

Last Auth # _____

PREVIOUS BH/SUD TREATMENT

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

List names and dates, include hospitalizations _____

_____

Substance Abuse ☐None ☐Rx History and/or ☐Current/Active

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

_____

CURRENT ICD DIAGNOSIS

Primary _____

R/O_____R/O_____

Secondary_____

Tertiary_____

Additional _____

Additional _____

CURRENT RISK/LETHALITY

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

PROVIDER INFORMATION

Provider Name (print) _____

Professional Credential: MD PhD Other _____

Provider TPI/NPI # _____

Provider Tax ID # _____

Hospital where ECT will be performed_____

Physical Address _____

Phone_____Fax_____

Hospital TPI/NPI # _____

Hospital Tax ID # _____

REQUESTED AUTHORIZATION FOR ECT

Inpatient or Outpatient:_____

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested _____

Frequency _____

Date first ECT _____ Date last ECT _____

Est. # of ECTs to complete treatment _____

Requested start date for authorization _____

LAST ECT INFO

Length_____Length of convulsion _____

*3, 4, or 5 please describe what safety precautions are in place

_____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)? ☐ Yes ☐ No ☐ N/A

PCP communication completed via: ☐ Phone ☐ Fax ☐ Mail Member Refused By _____

Coordination of care with other behavioral health providers? _____

Has informed consent been obtained from patient/guardian? _____

Date of most recent psychiatric evaluation _____

Date of most recent physical examination and indication of an anesthesiology consult was completed _____

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing _____

Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant _____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials) _____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment _____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occurred _____

Please indicate the plans for treatment and medication once ECT is completed _____

STANDARD REVIEW:
Standard 14-day time frame will be applied.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature Date

Clinician Signature Date

SUBMIT TO
Aetna Better Health of Illinois UM
Phone: 1-866-329-4701 Fax:1-844-528-3453