BlueCross BlueShield of Illinois

Electroconvulsive Therapy (ECT)
ECT REQUEST FORM

Provider must call Blue Cross Medicare Advantage PPO at 877-774-8592 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) _____

Previous MH/CD Treatment _____

Current Treatment Goals _____

Discharge Plan/Summary _____

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

My signature confirms that I am providing the requested services:

Signature _____ Date _____

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