Humana
Healthy Horizons™ in South Carolina

Healthy Connections

# ECT Behavioral Health Authorization Request Form

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

| | | |
|---|---|---|
| Date of Request: | Authorization Begin Date: | Authorization End Date: |
| Is this an initial authorization request? ☐ Yes ☐ No | If **no**, Date Treatment Began: | |

## Member Information

| | | |
|---|---|---|
| Last Name | First Name | Date of Birth |
| Phone Number | Humana ID# | Gender ☐ Male ☐ Female |
| Other Ins. ☐ Yes ☐ No | If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer. | Language Spoken |

## Requesting/Ordering Provider Information

| | | | |
|---|---|---|---|
| Last Name | First Name | TIN | NIP |
| Street Address | City, State, Zip | | Discipline/Specialty |
| Office Contact | Phone Number | | Fax Number |

## Servicing/Treating Provider Information

| | | | |
|---|---|---|---|
| Last Name | First Name | TIN | NIP |
| Street Address | City, State, Zip | | Discipline/Specialty |
| Office Contact | Phone Number | | Fax Number |

## Facility Information

| | | |
|---|---|---|
| Name | TIN | NPI |
| Street Address | City, State, Zip | |
| Office Contact | Phone Number | Fax Number |

## Requested Services

| Code | Description | Treatment Type/Setting | Units Requested |
|---|---|---|---|
| 90870 | Electroconvulsive therapy (includes necessary monitoring) | ☐ Initial Inpatient ECT<br>☐ Concurrent Inpatient ECT<br>☐ Initial Outpatient ECT<br>☐ Ongoing maintenance ECT | |

**Disclaimer:** An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

SCHL9W4EN0721

# ECT Behavioral Health Authorization Request Form

| Diagnosis | | | |
|---|---|---|---|
| Primary Diagnosis | | Secondary Diagnosis | |
| Medical/Co-occurring Diagnosis(es) | | | |

| Clearance | | | |
|---|---|---|---|
| Date of second opinion by Board Certified Psychiatrist | | Name of Psychiatrist | |
| Date of Medical MD assessment clearance: | | Name of Medical MD | |

| | | | | | |
|---|---|---|---|---|---|
| Date of pre-ECT lab work: | | Date of EKG: | | Date of Anesthesiologist clearance | |

Are any labs not WNL? ☐ **Yes** ☐ **No** If **yes**, please explain:

| | |
|---|---|
| Please included a copy of the following with your submission | ☐ Psychiatric Evaluation including psychiatric history supporting the need for ECT<br>☐ Informed Consent |

**Failure to submit the above documentation may delay the processing of your authorization request.**

Is any additional clearance needed/provided? ☐ **Yes** ☐ **No** If **yes**, please explain:

## Clinical Rationale and Treatment Information

Is ECT being performed OP? ☐ **Yes** ☐ **No**
If **yes**, where and how will the member be safely monitored after treatment?

What courses of medication have been tried and failed prior to requesting ECT and over what period of time? (List at least 2)

Provide an overview of all medical conditions including medications with a positive reaction:
(include condition/medication name, dates, and symptom improvement/resolution)

Provide an explanation of why ECT is the most appropriate course of treatment for the member:

# ECT Behavioral Health Authorization Request Form

| Current Medications | | | |
|---|---|---|---|
| Medication | Dosage | Frequency | Date Started |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Please explain the current treatment modalities and services currently in place: | | | |

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