



ECT AUTHORIZATION REQUEST

Check One:

Outpatient ☐

Inpatient ☐

Check One:

Initial Series ☐

Continuation Series

Requested Number of Sessions:

Requested Frequency:

Requested Start Date:

Requesting Hospital:

Client Medi-Cal Number:

Client Name:

Date of Birth:

Referring MD:

Administering MD:

Consulting MD (OP Only):

Administering MD Group Practice Name:

Contact Name

TEL:

FAX:

A. Primary ICD Diagnosis(es):

B. Indications for Initial ECT (Check Indications that are Present)

- ☐ Non-response to adequate medication trials for depression, mania, catatonia, or psychosis
- ☐ Rapid response needed due to medical risk in delaying ECT (e.g. dehydration)
If yes, what is the medical risk?
- ☐ Active danger to self/others
- ☐ Previous positive response to ECT

C. Attach the following:

1. Psychiatric Assessment by requesting MD
2. Most recent progress note
3. ECT Consult note
4. If Initial Outpatient ECT or Initial Inpatient ECT request, attach a medical clearance note.
If Continuation request, attach Clinical indication for continuation ECT & provide treatment plan (e.g., maintenance/tapering schedule etc.).

CI. Prior Episodes of Illness Treated with ECT:

Hospital:	# of ECT:	Date:	Response:	Time period to Relapse:
1.				
2.				

C2. Current Psychotropic Medication:

Medication:	Dose:	Start Date:	Response:	Current Blood Levels (Date Taken)
1.				
2.				
3.				
4.				

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

Optum Reviewed:

Comments:

☐ ECT

Determination:

☐ Client meets SMHS medical necessity criteria. Authorization request approved.

Start Date:

End Date:

Frequency:

Total # of Sessions:

Authorization request is ☐ Denied ☐ Modified ☐ Reduced ☐ Terminated ☐ Suspended

Date NOABD verbal notification to Provider:

Date NOABD & Letter of Determination Issued to Beneficiary and Provider:

NOABD clinical consultation summary & reason for denial:

Name of Optum Medical Director consulted and date:

Name of Optum Clinician/Licensure/Date:

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