



This form should be utilized for Blue Cross Medicare Advantage HMOSM and Blue Cross Medicare Advantage PPOSM Electroconvulsive Therapy Requests. Provider must call BCBSNM Medicare Advantage at 877-774-8592 or 877-688-1813 (DSNP) to verify benefits. Please complete all sections of the form and fax to BCBSNM at 505-816-4902.

Date _____

Check One:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Concurrent	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	ECT in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Past Frequency? _____ (x per week/month)	Brief Details of ECT to Date: _____
Is this a transition after IPECT? <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits Requested (CPT Code): <input type="checkbox"/> 90870 # _____
Current ECT Plan-Frequency: _____ (x per week/month)	Tentative Date of treatment: _____
Requested ECT Auth Start Date: _____	

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____

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 _____

