Geisinger

Electroconvulsive Therapy (ECT) Request Form

The attending physician/treating provider must complete this form. Fax the completed form and related clinicaldocumentation to 570-214-3573. If you have questions, call 888-839-7972.

Still faxing? If so, you may be missing out on timesaving benefits, including automatic approvals and guided submission only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes and unlocks access for all users at your practice organization.

Visit www.coherehealth.com/register to begin.

Request date: **Treatment start date:**

Member information:

Name: **DOB:**

Health plan ID: **Phone:**

Requesting provider information:

Name: **NPI:**

Phone: **Fax:** **TIN:**

Contact person:

Check here if requesting provider is also the ECT provider: ☐

ECT provider/facility information:

Name: **NPI:**

Facility: **TIN:**

Address: **City:** **State:** **Zip:**

Phone: **Fax:**

Current or provisional DSM 5 Diagnoses and ICD 10 code(s):

Request for:

Choose an item. ☐ Acute Treatment ☐ Extension of Acute Treatment ☐ Maintenance

CPT code: Choose an item. ☐ 90870 ☐ 90871 **# of sessions:**

Prior ECT treatment: ☐ Yes ☐ No

If yes, describe with dates, units and response:

Dates: Units: Response:

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Dates: Units: Response:

List all current and past medications (medical and psychiatric):

Medication:	Dose:	Dates:	Reason D/C:

Has member been compliant with past medication treatment? ☐ Yes ☐ No

Prior hospitalization(s):

Facility:	Dates:	Reason:

Current outpatient treatment(s):

Provider:	Dates:	Services:

Rationale:

What is the rationale for requesting ECT (e.g., failure of adequate trials of antidepressants, specific psychiatric or physical condition, unable to tolerate medication side effects)?

Provide the following specific details of the member's presentation:

Are there comorbid issues such as substance use? ☐ Yes ☐ No

If yes, describe:

Are there medical comorbidities/severe side effects that prevent appropriate medication treatment? ☐ Yes ☐ No

If yes, describe:

Attach copies of the following supporting documents:

- Current admission psychiatric evaluation (no older than 7 days), including mini mental status exam
- Current medical history and physical (no older than 7 days)
- Current urine drug screen results