BlueCross BlueShield of Montana

# Electroconvulsive Therapy (ECT)

# ECT REQUEST FORM

Provider must call BCBSMT at **855-313-8909** to check benefits.
For initial services, the Provider can complete this form and submit it through iExchange® or print and fax the completed form to BCBSMT at **855-649-9681.**

Date______________________

Check One: ☐ Initial Request ☐ Concurrent ☐ Discharge

Patient Name_______________________ Patient 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 ____________ Ext. ________ Fax ____________

ECT History: Has patient had ECT in the past? ☐ Yes ☐ No

Has patient had 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 list ICD-10 code(s), Diagnosis Name, Specifier and all Medical Diagnoses.

ICD-10 Code_______________ DX Name _______________ Specifier _______________

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Medications (Dosages)

Current Clinical Presentation/Risk Factors (Substance abuse: Include last date of use)

Previous MH/CD Treatment

Current Treatment Goals

Discharge Plan/Summary

My signature confirms that I am providing the requested services:

Signature _______________________________________ Date ________________

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