BlueCross BlueShield of Montana

Electroconvulsive Therapy (ECT)
ECT REQUEST FORM

Provider must call BCBSMT at **855-313-8909** to check benefits.
For initial services, providers can complete this form, print and fax the completed form to BCBSMT at
855-649-9681, or access the Availity® Authorizations tool and submit online.

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 _____
ICD-10 Code_____ DX Name _____ Specifier _____
ICD-10 Code_____ DX Name _____ Specifier _____
ICD-10 Code_____ DX Name _____ Specifier _____
ICD-10 Code_____ DX Name _____ Specifier _____

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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