Electroconvulsive Therapy (ECT) treatment request

Please use the self-service portal at **HumanaMilitary.com** for TRICARE referrals. If internet is not available, fax to (877) 378-2316.

Instructions: Please complete all the fields on the treatment request form. Please use the checklist when submitting TRICARE referrals through the self-service portal at **HumanaMilitary.com** to ensure that all necessary clinical information is included and to expedite authorization process.

History of ECT? If so, please provide the following information:

- Initial ECT request, concurrent continued or maintenance treatment ECT
- Response to treatment
- Date
- Frequency
- Lead placement: Unilateral or bilateral

List and describe trials of failed antidepressants:

- Name of medication
- Classification (SSRI, SNRI, TCA, MAOI, etc.)
- Duration
- Dosage
- Response to medication

Describe the desired observable outcomes and indicate whether the beneficiary agrees with the treatment goals.

If any of the following are present, please indicate on the referral/authorization request:

- Neurological condition(s) (epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, head trauma, primary or secondary tumor in the CNS, etc.)
- Metal located in or around the head
- Vagus nerve stimulator or implants controlled by physiologic signals (pacemakers, implantable cardioverter defibrillators, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, etc.)
- Past or present seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)
- Excessive use of alcohol or illicit substances within the past 30 days
- Severe cardiovascular disease
- Pregnant or breastfeeding

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Date submitted: _____

Beneficiary information

Patient name: _____

☐ M ☐ F DOB: _____ Patient ID or SSN: _____ Active Duty Service Member: ☐ Yes ☐ No

Address: _____

City: _____ State: _____ ZIP Code: _____

DoD benefit #: _____ Phone #: _____

Referring provider

Provider name: _____ TIN/NPI: _____

Military hospital or clinic/eMSM: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

Servicing provider

Provider type: ☐ M.D. ☐ D.O.

Provider name: _____ TIN/NPI: _____

Specialty: _____ Sub-specialty: _____

Facility name: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

Clinical indicator summary for ECT services: _____

_____

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Background information

Initial ECT request (requested frequency and administration): _____

Concurrent continued ECT request (past frequency and new frequency and duration requested): _____

Current psychiatric and medical conditions:

Dx (DSM-5/ ICD-10)	Onset	Description (include symptoms and treatment)

Current clinical symptoms: _____

Current medication(s):

Medication	Psychotropic	Medical	Prescribing MD	PCM	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

History of ECT: ☐ Yes ☐ No If yes, please describe treatment: _____

Response to ECT and any contra indicators to ECT	Date	Frequency	Response to medication	
			Unilateral	Bilateral
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Treatment scores from previous or continued service request for ECT treatment: _____

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Please list and describe trials of failed antidepressants including classification (SSRI, SNRI, TCA, MAOI, etc.)

Medication	Class	Duration	Dosage	Med compliance	Response to medication

Depression inventory tool completed (score and date): _____

Hx psychotherapy (dates of treatment): _____

Service request information

Anticipated start date: _____ Anticipated completion date: _____

Lead placement: ☐ Unilateral ☐ Bilateral Location: ☐ Inpatient ☐ Outpatient ☐ Combination

Initial TMS request (requested frequency and administration): _____

CPT code	Units	Frequency	Additional comments
90870			
90871			

Desired observable outcomes: Beneficiary agrees with treatment goals: ☐ Yes ☐ No

_____

Please respond to the following (mark all that apply):

☐ Neurological condition(s) (epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, head trauma, primary or secondary tumor in the CNS, etc.).

☐ Metal located in or around the head.

☐ Vagus nerve stimulator or implants controlled by physiologic signals (pacemakers, implantable cardioverter defibrillators, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, etc.).

☐ Past or present seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence).

☐ Excessive use of alcohol or illicit substances within the past 30 days.

☐ Severe cardiovascular disease.

☐ Pregnant or breastfeeding.

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program.

Provider signature: _____ Date: _____

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