

**Please Submit to the Dedicated Fax Line Below**

**Medicaid**

**South Carolina – 1-888-343-5364**

**MEMBER INFORMATION**

<b>Last Name</b>		<b>First Name, Middle Initial</b>		<b>Date of Birth</b>	
<b>Phone Number</b>		<b>WellCare ID Number</b>		<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Third-Party Insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>Yes</b> , please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		<b>Languages Spoken</b>	

**ORDERING PHYSICIAN/PRACTITIONER INFORMATION**

<b>Last Name</b>		<b>First Name</b>		<b>NPI Number</b>	
<b>WellCare ID Number</b>		<b>Type</b>	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist	<b>Specialty</b>	
<b>Participating</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Phone Number</b>		<b>Fax Number</b>	
<b>Street Address</b>		<b>City, State</b>		<b>ZIP</b>	
<b>Name of Requestor</b>			<b>Office Contact (if Different)</b>		

**TREATING PROVIDER/PRACTITIONER INFORMATION**

<b>Last Name</b>		<b>First Name</b>		<b>NPI Number</b>	
<b>WellCare ID Number</b>		<b>Participating</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Discipline/Specialty</b>	
<b>Street Address</b>		<b>City, State</b>		<b>ZIP</b>	
<b>Phone Number</b>		<b>Fax Number</b>		<b>Office Contact</b>	

**FACILITY/AGENCY INFORMATION**

<b>Name</b>		<b>Facility ID</b>		<b>NPI Number</b>	
<b>Street Address</b>		<b>City, State</b>		<b>ZIP</b>	
<b>Phone Number</b>		<b>Fax Number</b>		<b>Office Contact</b>	

**Service Type Requested**

**List REV/CPT/HCPCS Code(s) and Number of Each Requested**

<b>Initial Inpatient ECT</b>	
<b>Concurrent Inpatient ECT</b>	
<b>Initial Outpatient ECT</b>	
<b>Ongoing Maintenance ECT</b>	

**Service Request Start Date:**

**Diagnosis – Code and Description**

Indicate any change in diagnostic presentation

<b>Primary Diagnosis</b>	
<b>Secondary Diagnosis</b>	
<b>Medical Diagnoses</b>	

REQUEST SPECIFICATION AND CLEARANCE				
ECT in past 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of previous sessions overall?	
ECT used in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What was the treatment outcome of past ECT?				
<b>Include all supporting documentation for ECT clearance requirements below: (Failure to submit may delay processing of your request)</b>				
Date of second opinion by Board Certified Psychiatrist and MD Name:	Date of Pre-ECT Lab Work:	Date of EKG:	Date of Anesthesiologist Clearance:	Date of Medical MD/Assessment Clearance:
Any Labs not WNL? Explain.				
Additional Documentation:  Psychiatric Evaluation (to include member's psychiatric history to determine indication for ECT)  Informed Consent				
Any additional clearance needed/provided? Explain.				
CLINICAL RATIONALE				
Is ECT being performed for outpatient maintenance? If so, describe where and how the member will be safely monitored after treatment.				
What courses of medication have been tried and failed prior to requesting ECT? (List at least 2.) And over what period of time?				
Provide a thorough overview of all medical conditions – medications that had positive reaction (medication name; dates; symptom improvement)				
Provide a thorough explanation of why ECT is the best course of treatment for this member at this time.				
CURRENT MEDICATIONS (Psychotropic and Medical)				
Medication	Dosage	Frequency	Adherent?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any medication contraindications? If yes, describe.				