



Provider must call BCBSIL at 800-851-7498 to verify benefits. Fax to BCBSIL at 877-361-7656, or fax at 312-946-3736.

Date _____

Check One:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Concurrent	<input type="checkbox"/> Discharge
Patient Name _____	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 # _____ Fax # _____
ECT History: Any Past ECT? <input type="checkbox"/> Yes <input type="checkbox"/> No	ECT in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Past Frequency? _____ (x per week/month)	Brief Details of ECT to Date: _____
Is this a transition after IP ECT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current ECT Plan-Frequency: _____ (x per week/month)	Visits Requested (CPT Code): <input type="checkbox"/> 90870 # _____
Requested ECT Auth Start Date: _____	Tentative end date of treatment: _____

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____
Code #: _____	DX Name: _____	Specifier: _____

Medications _____

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

Previous MH/CD Treatment _____

Current Treatment Goals _____

Discharge Plan/Summary _____

Additional clinical information can be faxed with this form if needed.

My signature confirms that I am providing the requested services:

Signature _____ Date _____

