Prior Authorization Request Form

ECT (Electroconvulsive Therapy) Use only for Commercial LOB

Standard fax number: (844) 742-1155	**Urgent fax number: (844) 729-1416**

Use AuthAccel, Blue Shield of California's online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (**blueshieldca.com/provider**) and click the *Authorizations* tab to get started.

Blue Shield has a five business day turnaround time on all standard prior authorization requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Important for urgent requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to severe pain, potential loss of life, limb, or major bodily function, and a delay in decision-making might seriously jeopardize the life or health of the enrollee. If there is no MD signature present, the request will be processed as a standard request.

MD signature REQUIRED for urgent requests only:

Type of request: ☐ New standard request ☐ Retro request ☐ Urgent request

If you are submitting a modification or extension, check one, and complete the details below: ☐ Modification request ☐ Extension request

Previous authorization number:	Current last authorized day:	New authorization end date:

Provider justification for modification or extension:

Patient information

First name:	Last name:	
Date of birth (DOB):	Blue Shield subscriber ID number:	
Street address:	City:	
Home phone:	State:	ZIP code:
Cell phone:	Primary: ☐ Home ☐ Cell	
Require interpreter: ☐ Yes ☐ No ☐ American Sign Language		

Requesting provider

Provider first name:	Provider last name:	
Facility name:	Facility tax ID:	
Facility NPI:	Specialist type:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	

Servicing/rendering provider	**If same as requesting provider, check ☐**	
Provider first name:	Provider last name:	
Facility name:	Facility tax ID:	
Facility NPI:	Specialist type:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	

Place of service (check one box only):

☐ Outpatient Hospital ☐ Other (please specify) _____

CPT/HCPC code(s):

Procedure code	90870	00104	4066F	Other:
Number of visits				
Frequency				

Diagnosis: ICD-10 code(s):

*****See patient clinical information box below for required documentation*****

Requested start date of authorization:

Contact name: Contact fax number:

Contact phone: Is the voicemail confidential: ☐ Yes ☐ No

Patient clinical information

Please provide the following documentation:

History and physical and/or consultation notes including:

- ☐ Psychiatric evaluation
- ☐ Clinical findings (i.e., pertinent symptoms and duration)
- ☐ Standardized rating scales scores
- ☐ Activity and functional limitations
- ☐ Any history of ECT treatment and previous response
- ☐ Medication and other treatments attempted, including dose, modality, duration, and response (when applicable)
- ☐ Reason for procedure
- ☐ Treatment plan
- ☐ Prior conservative treatments, duration, and response, including medication trials
- ☐ Comorbidities
- ☐ Consultation and medical clearance report(s)
- ☐ Psychological and other pertinent multidisciplinary notes/reports when applicable

Post service (in addition to the above, please include the following):

- ☐ Procedure report(s)
- ☐ Results/reports of tests performed

If you have questions, please call Blue Shield Promise Behavioral Health Treatment Program at (888) 297-1325.