TRICARE ELECTROCONVULSIVE THERAPY (ECT) REQUEST

P.O. Box 551188, Jacksonville, FL 32255
Fax: (866) 811-4422

Network providers can submit authorization requests & clinical via the web at www.humana-military.com

IDENTIFYING DATA

Patient's Name: _____ DOB: _____ Sponsor #: _____

I. CLINICAL INFORMATION

DIAGNOSIS:

AXIS I: _____ AXIS II: _____ AXIS III: _____

CURRENT MEDICATIONS: (include all medications)

Medication	Dosage	Frequency	Start Date

CURRENT CLINICAL SIGNS AND SYMPTOMS (ENDOGENOUS):

_____

_____

_____

PREVIOUS ANTIDEPRESSANT (and augmentation) TRIALS:

Medication	Dosage	Date Initiated	Date D/C'd	Length of Tx at Therapeutic Dose

II. E.C.T. TREATMENT PLAN

NUMBER OF E.C.T. TREATMENTS REQUESTED: _____

☐ Unilateral ☐ Bilateral

☐ OUTPATIENT ☐ INPATIENT

IF INPATIENT E.C.T. IS REQUESTED, WHY IS OUTPATIENT E.C.T. CONTRAINDICATED FOR THIS PATIENT?

_____

_____

III. SUBMISSION INFORMATION

PROVIDER: _____ PROVIDER PHONE: _____

PROVIDER ID: _____ PROVIDER FAX: _____

FACILITY NAME: _____ FACILITY PHONE: _____

FACILITY ID: _____ FACILITY FAX: _____

FACILITY ADDRESS: _____

SUBMITTED BY: ☐ REQUESTING PROVIDER ☐ CASE MANAGER ON BEHALF OF PROVIDER

_____ _____

Signature Date

UM Original: 12/2011; Reviewed: 03/2013; 03/2014