



417 20<sup>th</sup> Street North, Suite 1100  
 Birmingham, AL 35203  
 Phone: 205-558-7475  
 Fax: 205-449-7049

## Electroconvulsive Therapy (ECT) Pre-Service Request

*(All information requested on this form must be complete.  
 Missing data may result in authorization delay.)*

- Submission of this information by fax or phone **does not** constitute authorization of services. VIVA's Behavioral Health UR department will notify you of their decision by secure email, mail, phone or fax.
- Please fax this completed form, along with the medical records documenting the clinical indications or medical necessity to the appropriate fax number listed below. For questions regarding this form, please call 205-558-7475.
- Please submit all elective prior authorization requests at least 10 days prior to the scheduled date of service.
  - Behavioral Health: Fax 205-449-7049

**PLEASE PRINT OR TYPE ONLY**

Member Name:		Member ID #:	Date:
Date of Birth:			
Facility Name:			
Requesting MD:		Telephone #:	
MD Performing ECT (if different):		Telephone #:	
Address where services are rendered:			
Submitting Staff Name/Credentials:			Phone #:
<b>Presenting Problem:</b>			
<b>Diagnoses:</b> <i>(List by name with accompanying code, include mental and substance use disorders, personality disorders, intellectual disabilities and medical conditions)</i>			
<b>Psychosocial and Environmental Stressors:</b>			
<b>Service Request:</b>			
How many treatments/what frequency are you requesting?			
What is the projected ECT start date?			
CPT Code(s) requested:		Total number of sessions requested:	
Treatment History (includes outpatient & inpatient with dates, locations and lengths of stay):			

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**CONFIDENTIALITY NOTICE:** The information transmitted with this facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately and destroy the related message. **Form BH-4/Revised 12182015**

Has a current medical assessment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a current psychiatric assessment with cognitive component been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Medications:</b>
Past Medication History (include past medications, dose, duration of Rx and response):
1.
2.
3.
4.
Current Medications (include dose, duration of Rx and response):
1.
2.
3.
4.
List any prior ECT series and outcomes the patient has had (with dates and locations):
Why is the client being referred for ECT at this time?

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