



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)

Table with 4 columns: Medication, Dosage, Frequency, Start Date

CURRENT CLINICAL SIGNS AND SYMPTOMS (ENDOGENOUS):

Blank lines for clinical signs and symptoms

PREVIOUS ANTIDEPRESSANT (and augmentation) TRIALS:

Table with 5 columns: 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 [] OUTPATIENT [] Bilateral [] INPATIENT

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

Blank lines for inpatient contraindication

III. SUBMISSION INFORMATION

PROVIDER: _____ PROVIDER PHONE: _____ FACILITY NAME: _____ FACILITY ID: _____ FACILITY PHONE: _____ FAX NUMBER: _____

SUBMITTED BY: [] REQUESTING PROVIDER [] CASE MANAGER ON BEHALF OF PROVIDER

Signature

Date

Disclaimer: Authorization indicates that medical necessity has been met but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit at the time services are rendered.