SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Electroconvulsive Therapy

Prior Authorization Request

Date ______________________________

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number

Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other ______________________________

Facility where services will be provided (include address if the provider provides services at more than one practice location)

Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

The Member has been diagnosed with:

- Catatonia ☐ Yes ☐ No
- Certain acute schizophrenic exacerbations ☐ Yes ☐ No
- Major depression (unipolar, bipolar, or mixed episode) with or without psychosis ☐ Yes ☐ No
- Mania, with or without psychosis ☐ Yes ☐ No

The Member has been:

- Unresponsive to effective medications, given for adequate dose and duration, that are indicated for the member's condition ☐ Yes ☐ No
- Unable to tolerate effective medications or has a medical condition for which medication is contraindicated ☐ Yes ☐ No
- Having favorable responses to ECT in the past ☐ Yes ☐ No
- Unable to safely wait until medication is effective ☐ Yes ☐ No
- Experiencing severe mania or depression or psychosis during pregnancy ☐ Yes ☐ No
- Member prefers ECT as a treatment option in consultation with the psychiatrist ☐ Yes ☐ No

Complete the questions for Continuation or Maintenance treatment depending on where the member is currently in their treatment. (Prior authorization is required after 10 visits are complete.)

Please include the most recent clinical update with the prior authorization request.

831-00057-64 (12/19)
© 2019 Security Health Plan of Wisconsin, Inc. All rights reserved. Written permission to reproduce or transmit this document in any form or by any means must be obtained from Security Health Plan of Wisconsin, Inc.

Continuation ECT Treatment

Continuation ECT treatment is ECT at 1 week intervals or longer for a period of 6 months:

- The individual has responded well to ECT ☐ Yes ☐ No
- Interval psychiatric and medical evaluations are completed prior to each treatment ☐ Yes ☐ No
- Frequency of sessions is at the minimum which sustains remission ☐ Yes ☐ No
- Continued need for ECT is reassessed every month ☐ Yes ☐ No
- Clinical treatment plans and consents are updated every month ☐ Yes ☐ No

Maintenance ECT Treatment

Maintenance ECT is the continuation of treatment for longer than 6 months at intervals of 2 weeks or longer:

- The individual has responded well to ECT ☐ Yes ☐ No
- Interval psychiatric and medical evaluations are completed prior to each treatment ☐ Yes ☐ No
- Frequency of sessions is at the minimum which sustains remission ☐ Yes ☐ No
- Continued need for ECT is reassessed every six months ☐ Yes ☐ No
- Clinical treatment plans and consents are updated every six months ☐ Yes ☐ No
- Does the member have a history of current relapse during maintenance pharmacotherapy ☐ Yes ☐ No
- Individual is unresponsive to maintenance pharmacotherapy ☐ Yes ☐ No
- Maintenance pharmacotherapy alone is insufficient to sustain remission ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

Provider signature ______________________ Date ____________

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	**Marshfield Clinic providers route to:**
Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.9918	Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.472.2363.

831-00057-64 (12/19) © 2019 Security Health Plan of Wisconsin, Inc. All rights reserved. Written permission to reproduce or transmit this document in any form or by any means must be obtained from Security Health Plan of Wisconsin, Inc.