



The provider must call BCBSTX at 1-866-355-5999 to check benefits. For initial services, the provider can complete this form and submit it through Availity or fax the completed form to BCBSTX at 1-877-361-7646.

Date \_\_\_\_\_

Check One: [ ] Initial Request [ ] Concurrent [ ] Discharge
Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_
Participant Name \_\_\_\_\_ Participant ID \_\_\_\_\_ Group # \_\_\_\_\_

Facility/Provider Name \_\_\_\_\_ NPI \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Primary MD Full Name \_\_\_\_\_ MD NPI \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
UR/Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Fax \_\_\_\_\_
ECT History: Has patient had ECT in the past? [ ] Yes [ ] No Past Frequency? \_\_\_\_\_ (x per week/month)
Has patient had ECT in the last six months? [ ] Yes [ ] No
Brief details of ECT to date: \_\_\_\_\_
Is this a transition after IP ECT? [ ] Yes [ ] No
Current ECT plan-frequency: \_\_\_\_\_ (x per week/month) Visits requested (CPT Code): [ ] 90870 # \_\_\_\_\_
Requested ECT auth start date: \_\_\_\_\_ Tentative end date of treatment: \_\_\_\_\_

Current DX — Please list ICD-10 code(s), Diagnosis (DX) Name, Specifier and all Medical Diagnoses.

ICD-10 Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
ICD-10 Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
ICD-10 Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
ICD-10 Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
ICD-10 Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_

Medications (Dosages):

Current Clinical Presentation/Risk Factors (Substance abuse: Include last date of use):

Previous MH/CD Treatment:

Current Treatment Goals:

Discharge Plan/Summary:

My signature confirms that I am providing the requested services:

Signature \_\_\_\_\_ Date \_\_\_\_\_



TECT