BlueCross BlueShield of Montana

Electroconvulsive Therapy (ECT)
ECT REQUEST FORM

Providers must call Blue Cross and Blue Shield of Montana (BCBSMT) at **855-313-8909** to check benefits.
For initial services, providers can complete this form, print and fax to BCBSMT at **855-649-9681**,
or access the Availity® Essentials Authorizations tool and submit online.

Date ______________________

Check One: ☐ Initial Request ☐ Concurrent ☐ Discharge

Patient Name ______________________ Patient Date of Birth ______________________
Subscriber Name ______________________ Subscriber ID ______________ Group ______________

Facility/Provider Name ______________________ NPI ______________________
Address ______________________ City ______________ State ______ Zip ______
Primary MD Full Name ______________________ MD NPI ______________________
Address ______________________ City ______________ State ______ Zip ______
Utilization Reviewer/Contact Name ______________________ Phone ______________ Ext. ______ Fax ______________
ECT History: Has patient had ECT in the past? ☐ Yes ☐ No
Has patient had ECT in the last 6 months? ☐ Yes ☐ No
Past frequency? ______________________(x per week/month)
Brief details of ECT to date: ______________________
Is this a transition after inpatient ECT? ☐ Yes ☐ No
Current ECT plan frequency ______________________(x per week/month)
Visits requested (Current Procedural Terminology (CPT®) code:) ☐ 90870 #__________
Requested ECT authorization start date ______________________
Tentative end date of treatment:______________________

Current DX – Please list ICD-10 code(s), diagnosis name, specifier and all medical diagnoses.

ICD-10 Code ______________ DX Name ______________ Specifier ______________
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Medications (dosages):

Current clinical presentation/risk factors (Substance abuse: Include last date of use):

Previous mental health or chemical dependency treatment:

Current treatment goals:

Discharge plan/summary:

My signature confirms that I am providing the requested services:

Signature ______________________________ Date ______________________

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