Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
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AETNA BETTER HEALTH® OF KENTUCKY

Initial & Concurrent ECT/TMS Prospective Request

Please complete and fax this review form to 855-301-1564 or SKY 1-833-689-1424

Optional Case Reference #_____

Today's date:	ECT Location ☐ IP ☐ OP ☐TMS		
Facility name:	MD name:		
Facility NPI #:	MD NPI #:		
Facility fax #:	MD direct phone #:	, Ext	
Patient name:	MD Fax #:		
Patient ID #:	Facility/MD services	Include:	Exclude:
Date ECT/TMS to begin:	DOB	Age	Sex ☐ M ☐ F

Diagnosis (Please report complete psychiatric diagnosis below)

Medications (Please report psychotropic medication below and include PRNs)

Primary ICD 10 diagnosis:	Medication (routine)	Amount	Freq.	Compliance
ICD 10 Diagnosis:				☐ Y ☐ N
ICD 10 Diagnosis:				☐ Y ☐ N
Comorbid Medical ICD 10 Dx:				☐ Y ☐ N
Comorbid Medical ICD 10 Dx:				☐ Y ☐ N
Psychosocial factors:	Medication (prn)	Amount	Freq.	Compliance
Attending psychotherapy? ☐ Y ☐ N Frequency:				☐ Y ☐ N

History: All of the following must be faxed along with this form

☐	Recent COMPREHENSIVE Psychiatric Evaluation	
☐	History of Psychiatric Treatment to date (include all levels of care); • Include onset, course, and severity of illness • Response to Treatment • Describe Patients overall Treatment Compliance • Include Prior ECT Treatments and Response to Treatment(s) (Positive or Negative): – Most recent stimulus, electrode / coil placement, and description of seizure response; – Response to Treatment (cognitive, affective, and behavioral progress); – Complications or Adverse effects	
☐	History of Substance Abuse Treatment to date (include all levels of care), & Date of last use:	
☐	Psychotropic Medication History (Include: Medications, Dates, Response, Adverse Affects)	
☐	Medical History and Medical Clearance (describe):	
List the Rating Scale(s) that were used to monitor progress?		
Baseline Score/Date:	Current Score/Date:	

Areas of concern: (please check all that apply)

☐ Presence of a cognitive disorder
☐ Lack of housing or family/social supports for transition from IP ECT to OP ECT
☐ Presence of a significant personality disorder

Proposed treatment plan:

TX Request for ☐ Initial (Index) ☐ Concurrent	ECT Code/# of visits requested: ☐ 0901 : # ☐ 90870 : #	Frequency/time span: Per week/month Dates: From To #Visits Completed to date
Lead placement: ☐Unilateral ☐ Bi-forntal ☐ Bi-temporal		
☐ Information consent obtained		
By signing below I attest the reported information to be true and accurate to the best of my knowledge and is congruent with the medical record.		
Request form completed by and credentials:		Date: