BlueCross BlueShield of New Mexico

Electroconvulsive Therapy (ECT)
ECT REQUEST FORM

Providers must call Blue Cross and Blue Shield of New Mexico (BCBSNM) at **888-898-0070** to check benefits.
For initial services, complete this form, print and fax to BCBSNM at **877-361-7659**,
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 _____