



Provider must call BCBSOK at 800-672-2378 to check benefits.

For initial services, the Provider can complete this form and submit it through iExchange® or print and fax the completed form to BCBSOK at 877-361-7660.

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 _____
UR/Contact Name _____ Phone _____ Ext. _____ Fax _____
ECT History: Has patient had ECT in the past? Yes No
Past Frequency? _____ (x per week/month)
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 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 _____

