

Electroconvulsive Therapy (ECT) / Transcranial Magnetic Stimulation (TMS) Concurrent Review Form

INSTRUCTIONS:

- Please submit the concurrent review request within 7 business days of member's last remaining scheduled treatment session.
- Email completed form along with five treatment session progress notes to the B – UHP Behavioral Health UM Department at UHPBHUM_OOH_CCR@Bannerhealth.com.

Date:		B – UFC Authorization Number:	
Member Name:			
AHCCCS:		DOB:	
Name of Servicing Provider Submitting Request:			
Requesting Provider Email Address:			
Backline:		Fax:	
Current Level of Care:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient with transition to outpatient		
Date of last session completed:		Number of Sessions Completed:	Number of sessions remaining on existing authorization:
Reason for Request:			
Request Start Date of Next Session:		Estimated Series End Date:	
Number of Sessions Requested:		Primary Diagnosis:	

Current Medications and any medication changes:

Medication	Dosage	Frequency	If New, Date Added	If Discontinued, Date

Clinical Summary of Progress (*any adjustments made due to response; barriers to treatment; any side effects of treatment, etc.*)

Describe the signs of continued improvement/clinical efficacy exhibited by the member.

Are additional sessions being requested in anticipation of further clinical improvement or to maintain any symptom remission that has been achieved.

What is the Long-Term Plan for the member?