MACOMB COUNTY COMMUNITY MENTAL HEALTH
ECT AUTHORIZATION FORM

Requesting Facility

____

I. Consumer Name____
ECT Tx Provider____

Case No ______________________________________ SSN _________________________

DOB ____ Adm Date____________________

Attending Physician

____
M. D. / D.O.

Second Opinion Physician

____
M. D. / D.O.

Date of Request_________________________________

II. ECT Requested

________ Inpatient _____ Outpatient / PHP (Circle One)

III. Approved □ No. of ECT's ______________ Denied □

Rationale for Denial ____

Effective Dates: From: ___________________ To: __________________

Review Dates:____

IV. Manage Care Operations Physician Reviewer:

(PRINT Name)____

____

Signature Date

cc: MCCMH Chief Medical Office Facility UR Coordinator
MCCMH Hospital Liaison
Account Clerk, MCCMH Manage Care Operations