BlueCross BlueShield of Montana

# Transcranial Magnetic Stimulation REQUEST FORM

Provider must call **Blue Cross and Blue Shield of Montana at 855-313-8909** to check the member's benefits.
Print and fax the completed form to BCBSMT at **855-649-9681**.

Request Submission Date:_____

| Check One | ☐ Initial Request ☐ Follow Up Request | Check One | ☐ rTMS ☐ dTMS |
|---|---|---|---|

**Patient and Member Information**

Patient Name _____ Patient Date of Birth_____ /_____ /_____

Subscriber Name _____ Subscriber ID _____ Group _____

**Provider Information (Individual and/or Group)**

Treating Provider/MD Name _____ Professional Licensure _____

Address _____ City _____ State_____ Zip _____

Email Address _____ Contact Name _____ Phone _____ NPI _____

Requested Service Dates ____ /_____ /_____ to ____ /_____ /_____ CPT Code(s) – Number of Sessions: 90867 – _____ ; 90868 – _____

**Clinical Information:** Date of depression onset _____/_____/_____ Manufacturer of TMS equipment _____

1. Current ICD-10 Diagnosis Code _____ DX Name_____ Specifier _____
2. Trial of antidepressant (minimum of two) and classification of medications (min of two) for MDD; for OCD trial of TCA and SSRI

   Medication Name _____ Maximum Dose _____ Class _____ Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
   Medication Name _____ Maximum Dose _____ Class _____ Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
   Medication Name _____ Maximum Dose _____ Class _____ Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
3. Currently or previously in psychotherapy known to effectively treat major depressive disorder? (Please check all that apply)

   ☐ Yes, currently Provider Name _____ Professional Licensure _____ Started ____ / ____ / _____
   ☐ Yes, in past Provider Name _____ Professional Licensure _____ Dates ____ / ____ / ____ to ____ / ____ / ____
   ☐ No. Reasons psychotherapy, such as Cognitive Behavioral Therapy, cannot be done: _____
4. National Standardized Rating Scales administered before, weekly during and after treatment?

   ☐ Yes Rating Scale being utilized _____
   ☐ No Reason _____
5. Are any of the following conditions present?

   ☐ Seizure disorder or any history of seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)
   ☐ Presence of acute or chronic psychotic symptoms or disorders in the current depressive episode (such as, schizophrenia or schizoaffective disorder)
   ☐ Neurological conditions that include history of epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system
   ☐ Excessive use of alcohol or illicit substances within the last 30 days
   ☐ No response by patient to a prior course of rTMS treatments (defined as not achieving at least a 50% reduction in severity of scores for depression in a standardized rating scale, i.e. PHQ-9, by the end of acute phase treatment)
   ☐ The patient has received a separate acute phase rTMS treatment in the past 6 months
   ☐ None of the above are present.

   I accept whatever number of units/days the clinical team determines is medically necessary and appropriate based on clinical submitted. Yes ☐ No ☐

Signature _____ Date _____

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