MERCY MANAGED BEHAVIORAL HEALTH

Transcranial Magnetic Stimulation (TMS) Request

Patient Information:

Name: ____________________ DOB: ____________________

Insurance ID #: ____________________ Current Age: ____________________

List all current diagnoses: ____________________

Requesting Provider Information:

Name of Physician: ____________________ TIN: ____________________

Name of Facility: ____________________ Billing NPI: ____________________

Service Address: ____________________

Office contact: ____________________ P: ____________________ F: ____________________

Clinical Criteria Information:

For the *current episode* of depression, list medication trials:

Medication #1: ____________________ Maximum Dose: ____________________

Trial Start Date: ____________________ Trial End Date: ____________________ Duration of Trial: ____________________

Outcome: ____________________

Medication #2: ____________________ Maximum Dose: ____________________

Trial Start Date: ____________________ Trial End Date: ____________________ Duration of Trial: ____________________

Outcome: ____________________

Medication #3: ____________________ Maximum Dose: ____________________

Trial Start Date: ____________________ Trial End Date: ____________________ Duration of Trial: ____________________

Outcome: ____________________

Medication #4: ____________________ Maximum Dose: ____________________

Trial Start Date: ____________________ Trial End Date: ____________________ Duration of Trial: ____________________

Outcome: ____________________

Clinical Criteria Information continued:

Medication Augmentation #1: ____ Maximum Dose: ___________________

Trial Start Date: __________________ Trial End Date: ___________________ Duration of Trial: ___________________

Outcome: ____

Medication Augmentation #2: ____ Maximum Dose: ___________________

Trial Start Date: __________________ Trial End Date: ___________________ Duration of Trial: ___________________

Outcome: ____

Clinical History Information:

List any prior TMS or ECT trials (include dates & number of treatments): ____

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Check Yes or No regarding the following contraindications:

Does the patient have a history of:	**Y**	**N**
Epilepsy or history of seizures except as induced by ECT and associated with febrile seizures in infancy	**Y**	**N**
Implanted devices sensitive to magnetic fields and within 30 cm of TMS coil	**Y**	**N**
Other psychiatric / neuropsychiatric disorders	**Y**	**N**
Is member currently clean/sober from any alcohol, prescription drug, or other substance abuse?	**Y**	**N**

Request Information:

CPT Code	**Requested Start Date**	**Number of Sessions/Units**
90867 – Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery & management		
90868 – Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session		
90869 – Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management		
Other, specify:		

By signing below you are confirming that the information you have provided on this form is accurate and complete based on your clinical assessment of the patient and the records available to you as of the date of this request.

Print Name: ____

Signature: ____ Date: __________________________

Fax completed forms to Mercy Managed Behavioral Health at 314-729-4636.