MERCY MANAGED BEHAVIORAL HEALTH

Transcranial Magnetic Stimulation (TMS) Request – Initial Course

Patient Information:

Name: _____ DOB: _____

Insurance ID #: _____

Requesting Provider Information:

Name of Physician: _____ TIN: _____

Name of Facility: _____ Billing NPI: _____

Service Address: _____

Office contact: _____ P: _____ F: _____

Clinical Criteria Information:

Is the member 18 years of age or older?	◯ Yes	◯ No
Does the member have a diagnosis of Major Depressive Disorder?	◯ Yes	◯ No
Dx Code: _____		
Does the member present with psychotic symptoms?	◯ Yes	◯ No
Does the member have any other psychiatric/neuropsychiatric disorders?	◯ Yes	◯ No
Does the member have epilepsy or history of seizure or presence of other neurologic disease that may lower seizure threshold?	◯ Yes	◯ No
Does the member have metallic hardware or implanted magnetic-sensitive medical device at a distance within the electromagnetic field of the discharging coil?	◯ Yes	◯ No
Does the member have a cochlear implant, deep brain stimulator, or vagus nerve stimulator?	◯ Yes	◯ No

If any of the contraindications are present, please provide additional information and clarify why TMS is being requested:

_____

_____

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

Warning: Failure to provide complete medication trial information may result in a delayed determination and/or denial of authorization.

Medication #1: _____ Maximum Dose: _____

Trial Start Date: _____ Trial End Date: _____ Duration of Trial: _____

Negative Side Effects documented? ◯Yes ◯No Member adherence documented? ◯Yes ◯No

Medication #2: _____ Maximum Dose: _____

Trial Start Date: _____ Trial End Date: _____ Duration of Trial: _____

Negative Side Effects documented? ◯Yes ◯No Member adherence documented? ◯Yes ◯No

Medication #3: _____ Maximum Dose: _____

Trial Start Date: _____ Trial End Date: _____ Duration of Trial: _____

Negative Side Effects documented? ◯Yes ◯No Member adherence documented? ◯Yes ◯No

Medication #4: _____ Maximum Dose: _____

Trial Start Date: _____ Trial End Date: _____ Duration of Trial: _____

Negative Side Effects documented? ◯Yes ◯No Member adherence documented? ◯Yes ◯No

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.