



Provider must call Blue Cross and Blue Shield of New Mexico (BCBSNM) at 888-898-0070 to check the member's benefits. Print and fax the completed form to BCBSNM at 877-361-7659.

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 ____/____/____ 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.

Signature _____ Date _____

