Transcranial Magnetic Stimulation
rTMS REQUEST FORM

This form should be utilized for **Blue Cross Medicare Advantage HMO℠ and Blue Cross Medicare Advantage PPO℠** Transcranial Magnetic Stimulation requests. Provider **must** call BCBSNM Medicare Advantage at 877-774-8592 or 877-688-1813 (DSNP) to verify benefits. Please complete all sections of the form and fax to BCBSNM at 505-816-4902

Check One: ☐ Initial Request ☐ Follow Up Request Request Submission Date:________

Patient Name______________________ Date of Birth____/____/____

Subscriber Name______________________ Subscriber ID #__________ Group #__________

Treating Provider/MD Name ______________________ Professional Licensure ______________________

Address______________________ City__________ State_____ Zip _______

Contact Name__________ Phone #__________ NPI#__________ TaxID#__________

Requested Service Dates_/_/_______ to_/_/_______ CPT Code(s) – # of Sessions: 90867 –______; 90868 – ______

Clinical Information: Current Depressive Episode Start Date:____/____/______

1. Current Diagnosis (Requiring rTMS Treatment):______________________ Specifier______________________
2. Trials of Failed Antidepressants (minimum of four) with its Classification (i.e. SSRI, SNRI, TCA, MAOI, Other):

   Antidepressant:______________________ Class:__________ Med Trial Dates__/__/__ to__/__/

   Antidepressant:______________________ Class:__________ Med Trial Dates__/__/__ to__/__/

   Antidepressant:______________________ Class:__________ Med Trial Dates__/__/__ to__/__/

   Antidepressant:______________________ Class:__________ Med Trial Dates__/__/__ to__/__/

   Antidepressant:______________________ Class:__________ Med Trial Dates__/__/__ to__/__/

   Antidepressant:______________________ Class:__________ Med Trial Dates / / to / /

3. Currently in Cognitive Behavioral Therapy or has had CBT Treatment (Please answer Yes or No)

   ☐ Yes, Currently Provider Name______________ Prof Licensure__________ Started__/__/______

   ☐ Yes, In Past Provider Name______________ Prof Licensure__________ Dates __/__/__ to __/__/ ☐

   No, Reasons why CBT cannot be done:

4. National Standardized Rating Scales being administered weekly during 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 (e.g., schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode

   ☐ Neurological conditions that include epilepsy history, 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 __________

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Such services are funded in part with the State of New Mexico.
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