BlueCross BlueShield of Oklahoma

Transcranial Magnetic Stimulation REQUEST FORM

Provider must call **Blue Cross and Blue Shield of Oklahoma at 800-672-2378** to check the member's benefits.
Print and fax the completed form to BCBSOK at **877-361-7660**.

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. Trials of failed antidepressants (minimum of two) with its classification (i.e. SSRI, SNRI, TCA, MAOI, Other)

   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 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 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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