BlueCross BlueShield of Texas

Transcranial Magnetic Stimulation
rTMS REQUEST FORM

Provider must call **BCBSTX at 1-866-355-5999** to check the participant's benefits. Print and fax the completed form to BCBSTX at **1-877-361-7646.**

Request Submission Date:_____

Check One ☐ Initial Request ☐ Follow Up Request

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 four) with its classification (i.e. SSRI, SNRI, TCA, MAOI, Other)

   Medication Name _____ Maximum Dose_____ Class _____ Med Trial Dates___/___/___ to ___/___/___
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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

Signature _____ Date _____