Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Repetitive Transcranial Magnetic Stimulation (rTMS)

Patient Name:_____ Enrollee ID#:_____ Date of Birth:_____

1. Have you evaluated the member clinically with at least one face-to-face session? Yes___ No___

2. What is the current primary diagnosis? _____
3. Has the patient received psychotherapy? ____ Yes ____ No

4. History of present illness/treatment resistant depression, please describe:

Please attach supporting clinical documentation*

_____

_____

_____

_____

_____

5. Has Electroconvulsive Therapy (ECT) been considered and discussed with the member? ____ Yes ____ No

_____

_____

6. Has the member participated is at least four antidepressant medication trials? ____ Yes ____ No

Please attach supporting clinical documentation*

_____

_____

_____

7. Please indicate below the number of units requested for rTMS

Covered Code	√	Proposed Treatment	# of Units
90876		*TMS Initial Treatment (Therapeutic Magnetic Stimulation)*	
90868		*TMS Subsequent delivery & management*	
90869		*TMS Re-determination with delivery management*	
		Total Units Requested:	=

MD/DO conducting treatment: _____

Facility Address:_____ Phone: _____

Contact Person: _____ Phone: _____ Date: _____

Mail form to: CBHA, Box 571137, Winston-Salem, NC 27157-1137 or FAX form to: (336) 499-4006