

## 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\*\***

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

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6. Has the member participated in at least four antidepressant medication trials? \_\_\_ Yes \_\_\_ No  
**\*\*Please attach supporting clinical documentation\*\***

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

Covered Code	√	Proposed Treatment	# of Units
90876	√	<i>TMS Initial Treatment (Therapeutic Magnetic Stimulation)</i>	
90868	√	<i>TMS Subsequent delivery &amp; management</i>	
90869	√	<i>TMS Re-determination with delivery management</i>	
	√		
	√		
	√		
	√		
	√		
<b>Total Units Requested:</b>			<b>=</b>

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: (888) 908-7140**

