BlueCross BlueShield of North Carolina

Use for Commercial and SHP Members

Fax: 866-987-4161

Transcranial Magnetic Stimulation – TMS
(including Repetitive TMS – rTMS)
AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval. Incomplete forms may delay processing. All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth

Requesting/Ordering Provider Information		Servicing Provider or Facility Location (for services to be performed outside of the provider's office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #		**Fax #**	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____

Authorization Request type (check One)	☐ **Initial Request** ☐ **Extension Request and previous reference/authorization #** _____	**Place of Service**	☐ **Office** ☐ **Outpatient Hospital** ☐ **Inpatient Hospital**
Requested TMS start date		**Expected End Date**	
CPT (Procedure Code) **Name of TMS Device**	☐ **90867 and # Units** _____ ☐ **90868 and # Units** _____ ☐ **90869 and # Units** _____ ☐ **Other** _____ _____	**Has patient had TMS previously?**	☐ **Yes (and last dates):** _____ ☐ **No**
Past Frequency	(X per week or per month)	**Is this a transition after inpatient TMS?**	☐ **Yes** ☐ **No**

If TMS previously administered (include details of dates of TMS and prior response)	**Date:**_____ **Response:**_____ **Date:**_____ **Response:**_____ **Date:**_____ **Response:**_____ **Date:**_____ **Response:** _____

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Current Medications (dosages, duration)	
Current psychological therapy (type, frequency, duration)	
Treatment History	Please provide details related to prior treatment history and response, including service category type (i.e. Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy). ☐ Please indicate if including as a separate attachment if necessary.
Clinical Assessment (please check all that apply)	☐ **Confirmed diagnosis of severe major depressive disorder (single or recurrent) documented by standardized rating scales that reliably measure depressive symptoms (Please include as separate attachment)** ☐ **Is rTMS ordered for continued treatment of the brain as maintenance therapy? ☐ Yes ☐ No**

Service Category	Dates	Reason for Admission	Response

Please list psychopharmacologic agents that member has been prescribed and trialed

Drug	Drug Class	Length of Trial/Start and End Dates	Max Dose	Member Response

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☐ **Please provide rationale for why electroconvulsive therapy would not be clinically superior to rTMS for this patient (i.e. in cases with psychosis, acute suicidal risk, catatonia or life-threatening inanition rTMS should NOT be used):**

☐ **Failure of a trial of a psychotherapy known to be effective in the treatment of major depressive disorder of an adequate frequency and duration, without significant improvement in depressive symptoms, as documented by standardized rating scales that reliably measure depressive symptoms.**

Please List Dates and Response to Treatment

Dates of Treatment	Response to Treatment

Does the patient exhibit any current signs or previous history of? (Please check all that apply)

☐ **Seizure Disorder or any history of seizure with increased risk of future seizure**

☐ **Presence of acute or chronic psychotic symptoms or disorders (i.e. schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode**

☐ **Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system.**

☐ **Presence of an implanted magnetic-sensitive medical device located within 30 centimeters from the TMS magnetic coil or other implanted items including but not limited to a cochlear implant, implanted cardioverter defibrillator, pacemakers, vagus nerve stimulator or metal aneurysm clips or coils, staples, or stents.**

For EXTENSION of acute or maintenance treatment ONLY:

☐ **Response to acute treatment:**

☐ **Goal/Rationale of continued acute treatment:**

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	☐ **Maintenance Treatment Rationale:** _____

By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature:_____ Date: _____

Fax this form with required documentation to Blue Cross NC Commercial Behavioral Health @ 866-987-4161.

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