BlueCross BlueShield of New Mexico

Transcranial Magnetic Stimulation REQUEST FORM

Provider must call **Blue Cross and Blue Shield of New Mexico at 888-898-0070** to check the member's benefits. Print and fax the completed form to BCBSNM at **877-361-7659**.

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. Trial of antidepressant (minimum of two) and classification of medications (min of two) for MDD; for OCD trial of TCA and SSRI

   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 administered before, weekly during and after 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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