REQUEST FOR TRANSCRANIAL MAGNETIC STIMULATION (TMS)

General Instructions:

- Complete all required fields (indicated by an *).
- Type or print neatly in the designated fields.
- Write the numerical diagnosis code(s) from the DSM-5 or ICD-10.
- Incomplete forms cannot be processed.

Submitting TMS Form

WebPass: https://webpass.ndbh.com/
Fax: 816-237-2364 (All except Blue KC Lucet Employee Group)

For Lucet Employees Only: *If your client is covered as a Lucet employee or a spouse or dependent of a Lucet employee (under Blue KC), please return by fax to 816-416-7788.*

Authorization is not required for:

- Blue Cross Blue Shield Alabama (except Federal Employee Program (FEP) and Southern Company group)
- Arkansas Blue Cross Blue Shield Federal Employee Program (FEP)
- Blue Cross Blue Shield Kansas

Medical Policy information is available on the Lucet website at https://lucethealth.com/providers/resources/mnc/.

For verification of benefits, eligibility, authorization requirements, and allowable codes, please call the customer service number listed on the member's insurance ID card.

TMS TREATMENT REQUEST FORM

Date of Request*: _____

Member's Information

Name*: _____ Insurance Policy #*: _____

Date of Birth*: _____ Phone #*: _____

Requesting Physician's Information

Name*: _____ Phone #*: _____

Address where services are being rendered*: _____

Tax ID#*: _____ NPI#*: _____

Office Staff's Contact Information

Name*: _____ Fax #*: _____ Phone #*: _____

TMS Information

Referring Physician's Name: _____

Referral Date: _____ TMS Start Date*: _____

Primary Diagnosis*: _____ Current Episode Duration (# months): _____

Other Diagnoses (Including Medical Diagnosis):

_____

Medication trials during current depressive episode:

Must document trials from at least two different antidepressant classes.

#	Medication Name	Max Daily Dose	Start Date	End Date	Discontinued due to lack of efficacy or adverse reaction	Document % response or disabling ADR
1*					◯ Efficacy ◯ Adverse Reaction	
2*					◯ Efficacy ◯ Adverse Reaction	
3					◯ Efficacy ◯ Adverse Reaction	

Maintenance and results: _____

Documentation of current levels of impairment (work, school, social, family, sleep, mood etc.):

_____

_____

_____

Pre-Treatment Depression Rating Scales (Required to complete at least one.*):

☐ PHQ-9 Score: _____ Date: _____
☐ BDI Score: _____ Date: _____
☐ MADRS Score: _____ Date: _____
☐ CGS Score: _____ Date: _____
☐ IDS-SR Score: _____ Date: _____
☐ IDS-C Score: _____ Date: _____

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. ○ Yes ○ No

Other clinical information or comments:

_____

_____

_____

Is this request for retreatment*? ○ Yes ○ No
If Yes:
Did the member respond to prior treatments, specifically with a 50% or greater improvement in a standard rating scale for depressive symptoms: ○ Yes ○ No
Date of the last TMS treatment session: _____

☐ PLEASE CHECK THIS BOX TO ATTEST TO THE FACT THAT ALL OF THE INFORMATION PROVIDED IS ACCURATE AND REFLECTED IN THE PATIENT'S MEDICAL RECORD.

Authorization if Determined to be Medically Necessary

1. Initial authorization:
   a. One (1) unit of 90867, 36 units of 90868, and one (1) unit of 90869.
   b. Requests for additional units of 90869 should be submitted with detailed clinical rationale.
2. Retreatment Requests
   a. 36 units of 90868

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