REQUEST FOR TRANSCRANIAL MAGNETIC STIMULATION (TMS)

General Instructions:

- All Member information (Member's Name, Date of Birth, Insurance ID Number, Member's Phone Number) must be completed, or form will be returned.
- Type or print neatly in the designated fields.
- Complete all fields.
- Write the numerical diagnosis code(s) from the DSM-5 or ICD-10.

Authorization is not required for:

- BCBS Alabama (Except Southern Company group)
- BCBS Arkansas Federal Employee Program (FEP)
- BCBS Kansas (Except Medicare)

Return via fax to the appropriate fax number:

- Lucet Employee: 816-416-7788

  If your client is covered as an employee of Lucet or a spouse or dependent of a Lucet employee, please return by fax to our Internal Behavior Health Benefit Review team**.**

- 816-237-2364
  - BCBS Alabama (Southern Company group)
  - BCBS Arkansas (Except FEP)
  - BCBS Florida (Florida Blue)
  - BCBS Kansas (Medicare)
  - BCBS Kansas City (Blue KC)
  - BCBS Louisiana
  - Imperial
  - Medicare (Except BCBS Alabama and BCBS Kansas)
  - SCAN
  - Walmart

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

Lucet™

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: _____

Antidepressant medication trials during this current depressive episode:

Must document at least two antidepressant trials.

Antidepressant only trials						
#	**Antidepressant 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: _____

Evidence-Based Psychotherapy Trials: (Type - DBT, CBT, ITP etc.)

Must document at least one full episode.

Type	Name of Clinician	Start Date	End Date	Results = % Response

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

_____

_____

_____

Pre-Treatment Depression Rating Scales (Required to complete one or more.):

☐ PHQ-9 Score: _____ Date: _____

☐ BDI Score: _____ Date: _____

☐ MADRS Score: _____ Date: _____

☐ CGS Score: _____ Date: _____

☐ IDS-SR Score: _____ Date: _____

☐ IDS-C Score: _____ Date: _____

Other clinical information or comments:

_____

_____

_____

☐ 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.

For TMS request found to be medically necessary, the following CPT codes and units will include:

90867 – One unit per course of treatment.

90868 – 36 units per course of treatment.

90869 – Approval of one unit will be provided.

Medical policy information is available at Lucethealth.com under Medical Necessity Criteria.