

Request for Repetitive Transcranial Magnetic Stimulation (rTMS) or Electroconvulsive Therapy (ECT)

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****

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

6. The member has participated in at least four antidepressant medication trials? ___ Yes ___ No
****Please attach supporting clinical documentation****

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

Covered Code	√	Proposed Treatment	# of Units
90876	√	<i>TMS Initial Treatment (Therapeutic Magnetic Stimulation)</i>	
90868	√	<i>TMS Subsequent delivery & management</i>	
90869	√	<i>TMS Re-determination with delivery management</i>	
90879	√	<i>ECT</i>	
	√		
	√		
	√		
	√		
Total Units Requested:			=

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

