Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Repetitive Transcranial Magnetic Stimulation (rTMS)

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*****

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

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6. Has the member participated is at least four antidepressant medication trials? ____ Yes ____ No
*****Please attach supporting clinical documentation*****

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

Covered Code	√	Proposed Treatment	# of Units
90867		*TMS Initial Treatment (Therapeutic Magnetic Stimulation)*	
90868		*TMS Subsequent delivery & management*	
90869		*TMS Re-determination with delivery management*	
		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: (336) 499-4006