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****

_____

_____

_____

_____

_____

5. Has Electroconvulsive Therapy (ECT) been considered and discussed with the member?_____Yes ____No

_____

_____

6. Has the member participated is at least two antidepressant medication trials?_____Yes ____No

***Please attach supporting clinical documentation****

_____

_____

_____

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

| Covered Code | ☒ | Proposed Treatment | # of |
|---|---|---|---|
| 90867 | | TMS Initial Treatment (Therapeutic Magnetic Stimulation) | |
| 90868 | | TMS Subsequent delivery & management | |
| 90869 | | TMS Re-determination with delivery management | |
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| | | | |
| | | | |
| | | **Total Units** | |

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**