BlueCross BlueShield of Illinois

Transcranial Magnetic Stimulation
rTMS REQUEST FORM

Provider must call Blue Cross Community MMAI at 877-723-7702 to verify benefits.
After completing the form, fax it to 312-233-4099.

Request Submission Date:_____

Check One: ☐ Initial Request ☐ Follow Up Request

Patient Name_____ Date of Birth_____/_____/_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Treating Provider/MD Name _____ Professional Licensure _____

Address_____ City_____State_____ Zip_____

Contact Name_____Phone #_____ NPI#_____Tax ID #_____

Requested Service Dates _____/_____/_____to _____/_____/_____ CPT Code(s) – # of Sessions: 90867 –_____; 90868 – _____

Clinical Information: Current Depressive Episode Start Date: _____/_____/_____

1. Current Diagnosis (Requiring rTMS Treatment): _____Specifier_____
2. Trials of Failed Antidepressants (minimum of four) with its Classification (i.e. SSRI, SNRI, TCA, MAOI, Other):

Antidepressant: _____ Class: _____ Med Trial Dates ___/___/___ to ___/___/___
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3. Currently in Cognitive Behavioral Therapy or has had CBT Treatment (Please answer Yes or No)

☐ Yes, Currently Provider Name_____ Prof Licensure_____ Started ____/_____/_____
☐ Yes, In Past Provider Name_____ Prof Licensure_____ Dates ___/___/___ to ___/___/___
☐ No, Reasons why CBT cannot be done:

4. National Standardized Rating Scales being administered weekly during treatment?

☐ Yes Rating Scale being Utilized: _____
☐ No Reason? _____

5. Are any of the following conditions present?

☐ Seizure disorder or any history of seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)
☐ Presence of acute or chronic psychotic symptoms or disorders (e.g., schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode
☐ Neurological conditions that include epilepsy history, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system
☐ Excessive use of alcohol or illicit substances within the last 30 days
☐ No response by patient to a prior course of rTMS treatments (defined as not achieving at least a 50% reduction in severity of scores for depression in a standardized rating scale (i.e. PHQ-9) by the end of acute phase treatment
☐ The patient has received a separate acute phase rTMS treatment in the past 6 months
☐ None of the above are present.

Signature _____ Date _____

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