



Provider must call Blue Cross and Blue Shield of Montana (BCBSMT) at 855-313-8909 to check the member's benefits. Print and fax the completed form to BCBSMT at 855-649-9681

Request Submission Date: \_\_\_\_\_

Check One [ ] Initial Request [ ] Follow Up Request Check One [ ] rTMS [ ] dTMS

Patient and Member Information Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group \_\_\_\_\_

Provider Information (Individual and/or Group) Treating Provider/MD Name \_\_\_\_\_ Professional Licensure \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_ Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ NPI \_\_\_\_\_ Requested Service Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ CPT Code(s) - Number of Sessions: 90867 - \_\_\_\_\_ ; 90868 - \_\_\_\_\_

Clinical Information: Date of depression onset \_\_\_\_/\_\_\_\_/\_\_\_\_ Manufacturer of TMS equipment \_\_\_\_\_

1. Current ICD-10 Diagnosis Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
2. Trial of antidepressant (minimum of two) and classification of medications (min of two) for MDD; for OCD trial of TCA and SSRI
Medication Name \_\_\_\_\_ Maximum Dose \_\_\_\_\_ Class \_\_\_\_\_ Med Trial Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Currently or previously in psychotherapy known to effectively treat major depressive disorder? (Please check all that apply)
[ ] Yes, currently Provider Name \_\_\_\_\_ Professional Licensure \_\_\_\_\_ Started \_\_\_\_/\_\_\_\_/\_\_\_\_
[ ] Yes, in past Provider Name \_\_\_\_\_ Professional Licensure \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
[ ] No. Reasons psychotherapy, such as Cognitive Behavioral Therapy, cannot be done: \_\_\_\_\_
4. National Standardized Rating Scales administered before, weekly during and after 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 in the current depressive episode (such as, schizophrenia or schizoaffective disorder)
[ ] Neurological conditions that include history of epilepsy, 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 \_\_\_\_\_

