BlueCross BlueShield of New Mexico

Transcranial Magnetic Stimulation
rTMS REQUEST FORM

Provider must call BCBSNM at 877-232-5518 to verify benefits.
After completing the form, fax it to BCBSNM at 505-816-4902.

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 ___/___/___
   Antidepressant: ______________________________ Class: ______________ Med Trial Dates ___/___/___ to ___/___/___
   Antidepressant: ______________________________ Class: ______________ Med Trial Dates ___/___/___ to ___/___/___
   Antidepressant: ______________________________ Class: ______________ Med Trial Dates ___/___/___ to ___/___/___
   Antidepressant: ______________________________ Class: ______________ Med Trial Dates ___/___/___ to ___/___/___
   Antidepressant: ______________________________ Class: ______________ Med Trial Dates ___/___/___ to ___/___/___
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 ________________

Such services are funded in part with the State of New Mexico.
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