# Behavioral Health Care Management

## Transcranial Magnetic Stimulation (TMS) Treatment Request

**COMPLETE ALL SECTIONS (A-J) See Accompanying Instructions on Page 2**

2650 Novation Parkway
Madison, WI 53713
Phone (800) 683-2300
(608) 640-4450
Fax (608) 471-4391

| **A: MEMBER INFORMATION** | |
|---|---|
| Name: | Date of Birth: |
| Member Number: | |

| **B: REFERRAL SOURCE / REQUESTING PSYCHIATRIST** | | |
|---|---|---|
| Provider Name: | Phone: | Fax: |
| Facility/Clinic Name: | Last Date Seen by Referring Provider: | |

| **C: REQUESTED TREATMENT PROVIDER INFORMATION** | | |
|---|---|---|
| Facility Name: | Provider Name: | |
| Facility Address: | | |
| Contact Name: | Phone: | Fax: |

| **D: SERVICE INFORMATION: TMS** | |
|---|---|
| Number of Visits/Days Requested: | Begin/End Date of Requested Service: ___ /___ /___ to ___ /___ /___<br>mm dd yy mm dd yy |

| **E: DSM-5/ICD-10 CODES AND DESCRIPTION** | | **F: OBJECTIVE ASSESSMENT INFO (PHQ-9, BDI, HAM-D, etc.):** |
|---|---|---|
| ***Code:*** | ***Description:*** | ***Objective Assessment Tool Used:*** |
| | | Scale Used: |
| | | Date: |
| | | Score: |

| **G: PREVIOUS MEDICATION TRIALS** | |
|---|---|
| Medication:<br>*Reason for Discontinuation:* | Medication:<br>*Reason for Discontinuation:* |
| Medication:<br>*Reason for Discontinuation:* | Medication:<br>*Reason for Discontinuation:* |
| Medication:<br>*Reason for Discontinuation:* | Medication:<br>*Reason for Discontinuation:* |

| **H: CURRENT MEDICATIONS AND PRESCRIBER** | | | |
|---|---|---|---|
| Medication: | Prescriber: | Medication: | Prescriber: |
| Medication: | Prescriber | Medication: | Prescriber: |

**I: HAS PATIENT EVER RECEIVED TMS?** ☐ YES ☐ NO Date Span:_____

**If YES, provide evidence of improvement with rating scales (i.e. PHQ-9, BDI, HAM-D, etc). Include pre, concurrent & post ratings/scores:**

| | | |
|---|---|---|
| *(Pre)* Scale Used: | Score: | Date Administered:___/___/___ |
| *(Concurrent)* Scale Used: | Score: | Date Administered:___/___/___ |
| *(Post)* Scale Used: | Score: | Date Administered:___/___/___ |

**J: ELECTROCONVULSIVE THERAPY (ECT) CANDIDATE**

*Explain*:_____

_____

_____

_____

## Instructions for BHCM Transcranial Magnetic Stimulation (TMS)

**A. MEMBER INFORMATION:** Name **and** Date of Birth are **essential**—please ensure correct spelling and DOB; lack of this identifying information will delay processing.

**Member Number:** This is the individual's Insurance ID number. It is okay to leave blank if you don't have this information.

**B. REFERRAL SOURCE/REQUESTING PSYCHIATRIST:** This is the name of the psychiatrist completing this form. Please provide your phone number **&** fax number.

**Last Date Seen by Referring Provider:** Identify the date last seen by the referring psychiatrist.

**C. REQUESTED TREATMENT PROVIDER INFORMATION:**

**Facility Name:** This is the facility/clinic where the TMS will be administered.

**Provider Name:** This is the individual psychiatrist who will be administering the TMS treatment.

**Facility Address:** If this is a Quartz in-network provider, please be sure to put the city name for location. If this is an out-of-network location (non-Quartz provider), please include the address of the facility.

**Contact Name/Phone/Fax:** If you are a facility/program making an internal referral, please complete this information for the **Requested Treatment Provider**. If you are referring to a provider outside of your own facility, it is okay to leave blank.

**D. SERVICE INFORMATION:**

**Number of Sessions Requested:** This is typically only completed by a program/facility. Individual providers can leave this section blank.

**Begin/End Date of Requested Service:** This is typically only completed by a program/facility. Individual providers can leave this section blank.

**E. DSM-5/ICD-10 CODES AND DESCRIPTION:** Provide specific code as well as any subtypes and/or specifiers.

**F. OBJECTIVE ASSESSMENT INFO:** Include what specific objective assessment tool was used to support diagnosis for major depressive episode. Include the date the most recent assessment was administered and the score obtained.

**G. PREVIOUS MEDICATION TRIALS:** List previous medications used to treat depressive episodes and the reason those medications were discontinued.

**H. CURRENT MEDICATIONS/PRESCRIBER(S):** List current medications being used to treat depressive episodes and who prescribes.

**I. HAS PATIENT EVER RECEIVED TMS:** If yes, provide date span when previously received TMS. Provide evidence of improvement with previous TMS sessions by identifying the assessment scale used, scores, and dates assessment scales were administered.

**J. ELECTROCONVULSIVE THERAPY (ECT) CANDIDATE:** Identify whether this patient has ever received ECT or been a candidate for ECT. Explain rationale for using TMS is patient received ECT or is a candidate.