Behavioral Health Care Management Transcranial Magnetic Stimulation (TMS) Treatment Request

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Please write clearly and legibly — complete all sections.
See accompanying instructions on page 3.

A. MEMBER INFORMATION

Name:	Date of Birth:
Quartz Insurance ID Number:	Member Phone 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:

Provider Name:	Phone:	Fax:

D. TMS SERVICE INFORMATION

Number of Visits/Days Requested:	Begin/End Date of Requested Service: ____/____/____ to ____/____/____ mm dd yy mm dd yy

E. DSM-5/ICD-10 CODES AND DESCRIPTION

Procedure Code (s):	DSM-5 Code(s):	Description:

F. OBJECTIVE ASSESMENT INFORMATION (PHQ-9, BDI, HAM-D, ETC.)

Scale Used:

Date:

Score:

G. PREVIOUS MEDICATION TRIALS

Medication: Reason for Discontinuation:	Medication: Reason for Discontinuation:
Medication: Reason for Discontinuation:	Medication: Reason for Discontinuation:
Medication: Reason for Discontinuation:	Medication: Reason for Discontinuation:

H. CURRENT MEDICATIONS AND PRESCRIBER

Medication:	Prescriber:	Medication:	Prescriber:
Medication:	Prescriber:	Medication:	Prescriber:

I. TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT

Has The 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, and post ratings/scores

(Pre) Scale Used:	Score:	Date Administered: _____ / _____ / _____ mm dd yy
(Pre) Scale Used:	Score:	Date Administered: _____ / _____ / _____ mm dd yy
(Pre) Scale Used:	Score:	Date Administered: _____ / _____ / _____ mm dd yy

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.

Quartz Insurance ID 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 if patient received ECT or is a candidate.