BlueCross BlueShield of Illinois

Transcranial Magnetic Stimulation
rTMS REQUEST FORM

Provider must call BCBSIL at 800-851-7498 to verify benefits.
After completing the form, fax it to BCBSIL at 877-361-7656.

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 ___/___/___
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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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