Transcranial Magnetic Stimulation Services: Supplemental Information

Please provide the following supporting information when requesting Medical Necessity Determination (MND) review of Outpatient Transcranial Magnetic Stimulation (TMS) services to be provided to a member.

Please include a separate sheet(s) if there is not sufficient room for your responses. Completed information may be included as attachments to the request you submit through our Utilization Management Request Tool, accessible via NaviNet.

Member Information

Member Name ______________________________

Member Date of Birth ______________________________

Subscriber ID Number ______________________________

Provider Information

Practitioner Name ______________________________

Practitioner Type 1 NPI ______________________________

Group/Facility Name ______________________________

Group/Facility TIN or Medicare Number ______________________________

Group/Facility Address ______________________________

Requestor Name ______________________________

Requestor Phone ______________________________

Present Illness Information

Assessment Scales (include Assessment Scale name and member score)

____

Prior Treatment History

Medication Trials (include medication name, dosage and dates)

____

Prior TMS or ECT Services Received (include type of service and dates)

____

Prior Psychotherapy (if applicable)

____

Treatment Plan

Requested Start Date of Service ____

Requested End Date of Service ____

Treatment Frequency and Duration ____

Additional Treatment in Conjunction with TMS (if applicable)

____

Plan of Care

Concurrent Review (please indicate member progress)

____

Discharge Plan

____

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