Geisinger
Health Plan

Transcranial Magnetic Stimulation (TMS) Request Form

The attending physician/treating provider must complete this form. This form must be completed electronically, printed and faxed. No handwritten forms will be accepted. Please fax the completed form to 570-214-4539. If you have questions regarding this form, please call 888-839-7972.

Date of request:

Proposed start date of TMS therapy:

Member's name: Date of birth:

Member's Health Plan ID: Telephone:

Requesting TMS psychiatrist/neurologist name:

NPI:

Address:

Contact name: Contact telephone:

Contact fax:

Servicing provider name:

Servicing provider NPI:

Address:

Contact name:

Contact phone: Fax:

The psychiatrist providing TMS must be certified to provide TMS therapy. The psychiatrist providing TMS must also attest below that any additional individual providing TMS to the member identified on this form is trained in basic life support and management of complications such as seizures in addition to training on the TMS apparatus and will be present with the member at all times while the treatment is applied. The physician will assess the member at each treatment and be present in the area, but not necessarily provide the treatment. Additionally, access to emergency equipment, including cardiac defibrillator and suction, is readily available while the member is receiving TMS.

By checking this box, I attest that the enclosed information is true, correct and complete and that my agency and I are in compliance with the statement above.

Name: Date:

Is the member and/or legal guardian able to understand the purpose, risks and benefits of TMS and provide consent?

Yes No

Provide all medical, psychiatric and substance abuse ICD-10/DSM diagnoses:

Describe onset of depressive disorder and nature of presentation (include past response to antidepressant medication(s) and/or TMS or ECT with dates and locations.

Date of onset:

Clinical presentation:

Describe history of psychotherapy for depression:

1. Date from: to:
   Provider's name and credentials:

   Type of therapy/treatment and modality:

   Frequency of visits:

   What was effective/not effective about this treatment?

2. Date from: to:
   Provider's name and credentials:

   Type of therapy/treatment and modality:

   Frequency of visits:

   What was effective/not effective about this treatment?

3. Date from: to:
   Provider's name and credentials:

   Type of therapy/treatment and modality:

   Frequency of visits:

   What was effective/not effective about this treatment?

Provide a list of all current medications (psychotropic and non-psychotropic), including dosage and frequency:

List a minimum of two failed trials of psychopharmacologic agents (include dates prescribed, duration of trial and dosages):

1.

2.

OR, list two trials of psychopharmacologic agents member is/was unable to tolerate at a therapeutic does, with distinct side effects (include dates prescribed, duration of trial and dosages):

1.

2.

Is the member medically stable?

Yes No

Document any co-morbid medical conditions the member has:

Are there any contraindications to TMS, including cochlear implant, deep brain stimulator, vagus nerve stimulator, epilepsy, history of seizure or metallic or hardware/implanted magnetic-sensitive medical device?:

Yes No

Is member a candidate for ECT? If so, what is the reason for rejecting treatment?

Yes No

Describe prior treatment history (inpatient, residential, partial hospitalization, intensive outpatient or any previous TMS treatment episodes) with dates and locations.

Describe how the member has demonstrated the ability to follow through on treatment recommendations:

Describe your treatment goals, with time frames, expected frequency of TMS sessions and measurable objectives:

Will the member be released to a person who can monitor and provide supportive care as needed to the member?

Yes No

Describe the frequency of face-to-face evaluations between the member and psychiatrist:

Treatment services

Requesting sessions for CPT code 90867

Requesting sessions for CPT code 90868

Requesting sessions for CPT code 90869