Geisinger

Transcranial magnetic stimulation (TMS) request

The attending physician/treating provider must complete this form. Fax the completed form and pertinent clinical documentation to 570-214-3573. If you have questions, call 888-839-7972.

Still faxing? If so, you may be missing out on timesaving benefits, including automatic approvals and guided submission only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes and unlocks access for all users at your practice organization.

Visit www.coherehealth.com/register to begin.

Request date: **Treatment start:**

Member information:

Name:

Health plan ID:

DOB: **Phone:**

Requesting provider:

Name:

NPI: **TIN:**

Address:

City: **State:** **Zip:**

Phone: **Fax:**

Contact: **Phone:**

☐ **Check here if requesting provider is the same as servicing provider**

Servicing provider:

Name:

NPI: **TIN:**

Address:

City: **State:** **Zip:**

Phone: **Fax:**

Contact: **Phone:**

Requested services:

☐ 90867 _____ sessions

☐ 90868 _____ sessions

☐ 90869 _____ sessions

Provide all medical, psychiatric, and substance use disorder DSM 5 diagnoses and ICD-10 codes:

Has the member failed trials with at least two psychopharmacologic agents? ☐ Yes ☐ No
If yes, list:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Or, list two trials of psychopharmacologic agents member is/was unable to tolerate at a therapeutic dose, with distinct side effects:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

List all current medications (medical and psychiatric):

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Describe onset of depressive disorder and nature of presentation (include past response to antidepressant medication(s).

Prior TMS treatment: ☐ Yes ☐ No

If yes, describe with dates, units, and response:

Dates:

Units:

Response:

Dates:

Units:

Response:

Dates:

Units:

Response:

Inpatient psychiatric admissions: ☐ Yes ☐ No

Facility:

Dates:

Reason:

Facility:

Dates:

Reason:

Outpatient treatment(s):

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Outpatient treatment(s):

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Document medical comorbidities:

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**

Attach copies of the following supporting documents:

- Current admission psychiatric evaluation (no older than 7 days), including mini mental status exam
- Current medical history and physical (no older than 7 days)
- Current urine drug screen results