Transcranial Magnetic Stimulation (TMS) Request Form

EVERNORTH℠

Evernorth Provider website provider.evernorth.com

This form should be completed by the clinician who has a thorough knowledge of the Evernorth customer's current clinical presentation and his/her treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

Please complete this form, save it to your computer, then email it to:
TMSBehavioralClinical@Evernorth.com (preferred) or fax 860-687-7329.

TIPS FOR COMPLETING THIS FORM:

- To help expedite processing of this request, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Our email is secure and authenticated. Please do not send encrypted messages.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.

☐ Initial request ☐ Concurrent request	**Date of Request:**	**Number of TMS treatments requested:**

Customer Name:	**Customer ID:**	**Date of Birth:**

1. Name of provider who will provide the TMS Treatment:

TIN:	☐ In-network provider* ☐ Out-of-network provider* ☐ Network Exception Request	Phone Number:

Service Address:	Apt/Ste#:	City:	State:	Zip Code:

2. ☐ Requesting provider is the same as the treatment provider:

Name of requesting provider:	TIN:	Phone Number:

Mailing Address:	Apt/Ste#:	City:	State:	Zip Code:

3. Name of person at provider's office to notify with the decision: | **Phone Number:**

4. Requested start date for treatment, if authorization is granted:

5. Primary Diagnosis: ☐ F32.1 MDD single episode, moderate ☐ F33.1 MDD recurrent, moderate w/out psychosis
☐ F32.2 MDD single episode, severe ☐ F33.2 MDD recurrent, severe, w/out psychosis

Other primary diagnosis and ICD-10 code: Yes: _____ ☐ Primary ☐ Secondary ☐ N/A

Has the customer ever been diagnosed with any other psychiatric conditions? If yes, please explain**:**

Medical diagnoses or concerns:

Transcranial Magnetic Stimulation (TMS) Request Form *(Continued)*

6. Clinical Information: The current episode of depression began (Month/Year): ____/ ______.

Last substance use date: ____________________ **Substance(s) used:** ____

In the space below, please provide a description of the customer's symptoms and functional impairments:

Onset of symptoms/ precipitating events:

Current symptoms and functional impairments:

7. Are there any risk of harm concerns including suicidal or homicidal ideation or self-injurious behavior?

☐ **Yes** ☐ **No** **If Yes, please explain:**

8. Assessment scale used to monitor depression:

Type: PHQ-9 ☐ QIDS ☐ BDI II ☐ HAM-D ☐ Other: ______________________

Date of most current assessment: ____________ Score: ______________________

9. Medication History:

Please document all current and past psychopharmacologic agents the customer has tried.

Name(s):	Classification of anti-depressant:	Dosages:	Start Date / End Date (MM/YY)	Response/side effects:
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	
	☐ SSRI ☐ SNRI ☐ MAOI ☐ Tricyclic ☐ Other: ________		___/ ___ to ___/ ___	

Transcranial Magnetic Stimulation (TMS) Request Form *(Continued)*

10. Has the customer received evidence based outpatient (OP) psychotherapy that addressed the current issues without significant improvement in depressive symptoms? (Please attach validated depression monitoring scales if available).

☐ **Yes, *(please complete section below)***

☐ **No history of OP psychotherapy**

Inpatient and/or Outpatient TX History/ Response:

Facility/Provider name/credentials:

TX Dates and frequency (MM/YY- MM/YY):

11. Does the customer have current or history of: ☐ **Seizures** ☐ **Substance use**

☐ Yes, response:

☐ If current, they are being addressed via:

☐ No

12. Does the customer have ferromagnetic or other magnetic-sensitive metals implanted within 30 cm of the TMS magnetic coil? ☐ **Yes** ☐ **No**

13. Does the customer have a history of previous good response to TMS?

☐ Yes*, dates of TMS treatment (pre/post scores):

Date span of treatment: ____ to ____

Date span of treatment: ____ to ____

Date span of treatment: ____ to ____

Date span of treatment: ____ to ____

Date span of treatment: ____ to ____

Pre score assessment scale & date: _____ Post score assessment scale & date: _____

Pre score assessment scale & date: _____ Post score assessment scale & date: _____

Pre score assessment scale & date: _____ Post score assessment scale & date: _____

Pre score assessment scale & date: _____ Post score assessment scale & date: _____

Pre score assessment scale & date: _____ Post score assessment scale & date: _____

☐ No

*Submit clinical evidence of improvement including standard rating scales (pre and post scores) for depressive symptoms.

Signature of requesting provider: _____ **Date:** _____

Print requesting provider name: _____ **Fax:** _____

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* "Evernorth Behavioral Health" refers to Evernorth Behavioral Health, Inc. and subsidiaries of Evernorth Behavioral Health, Inc., including Evernorth Behavioral Health of California, Inc., and Evernorth Behavioral Health of Texas.