Tennessee Transcranial Magnetic Stimulation (TMS) Request Form

EVERNORTH℠

For Behavioral Providers

To file electronically, providers in Tennessee must register for access to the online prior authorization tool:

To file via facsimile send to:
860.687.7329

To file via email send to:
TMSBehavioralClinical@Evernorth.com ***(preferred)***

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

Transcranial Magnetic Stimulation (TMS) Request Form

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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.*

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

_____

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

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

* "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.

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