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 Patient's current clinical presentation and his/her treatment history. *Please note: The information contained in this form may be released to the Patient or the Patient'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.

Date of Request:	**Number of TMS treatments requested:**

Patient Name:	**Patient ID:**	**Date of Birth:**
Patient Current Home Address:		

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: ***(Select One ONLY)***

- ☐ F32.1 MDD single episode, moderate
- ☐ F32.2 MDD single episode, severe
- ☐ F42.3 Hoarding disorder
- ☐ F42.8 Other obsessive-compulsive disorder
- ☐ F33.1 MDD recurrent, moderate w/out psychosis
- ☐ F33.2 MDD recurrent, severe, w/out psychosis
- ☐ F42.2 Mixed obsessional thoughts and acts
- ☐ F42.4 Excoriation (skin-picking) disorder
- ☐ F42.9 Obsessive-compulsive disorder, unspecified

Secondary diagnosis, if any: Yes: _____ ☐ N/A

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

_____

Medical diagnoses or concerns:

_____

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

Last substance use date: ________________ **Substance(s) used:** ______________________________

In the space below, please provide a description of the Patient'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 or OCD:

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

Date of most current assessment: __________ Score: ____________________

9. Medication History:

☐ If MDD Diagnosis, have at least 2 antidepressants been used for a trial of 4 or more weeks (during the current episode of depression)?

☐ If OCD Diagnosis, have at least 2 medications for the treatment of OCD been used for a trial of 8 weeks?

Please document all current and past psychopharmacologic agents the Patient 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 Patient received evidence based outpatient (OP) psychotherapy that addressed the current issues without significant improvement in related symptoms? (Please attach validated relevant 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 Patient have current or history of: ☐ **Seizures** ☐ **Substance use**

☐ Yes, response:

☐ If current, they are being addressed via:

☐ No

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

13. Does the Patient have a history of 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).

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.