



Provider must call **Blue Cross and Blue Shield of Illinois at 800-851-7498** to check the member's benefits.  
Print and fax the completed form to BCBSIL at **877-361-7656**.

Request Submission Date: \_\_\_\_\_

Check One	<input type="checkbox"/> Initial Request <input type="checkbox"/> Follow Up Request	Check One	<input type="checkbox"/> rTMS <input type="checkbox"/> dTMS
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<b>Patient and Member Information</b>	
Patient Name _____	Patient Date of Birth ____ / ____ / ____
Subscriber Name _____	Subscriber ID _____ Group _____

<b>Provider Information (Individual and/or Group)</b>	
Treating Provider/MD Name _____	Professional Licensure _____
Address _____	City _____ State ____ Zip _____
Email Address _____ Contact Name _____	Phone _____ NPI _____
Requested Service Dates ____ / ____ / ____ to ____ / ____ / ____	CPT Code(s) – Number of Sessions: 90867 – ____ ; 90868 – ____

<b>Clinical Information:</b>	Date of depression onset ____ / ____ / ____    Manufacturer of TMS equipment _____
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1. Current ICD-10 Diagnosis Code \_\_\_\_\_ DX Name \_\_\_\_\_ Specifier \_\_\_\_\_
2. Trial of antidepressant (minimum of two) and classification of medications (min of two) for MDD; for OCD trial of TCA and SSRI
 

Medication Name _____	Maximum Dose _____	Class _____	Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
Medication Name _____	Maximum Dose _____	Class _____	Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
Medication Name _____	Maximum Dose _____	Class _____	Med Trial Dates ____ / ____ / ____ to ____ / ____ / ____
3. Currently or previously in psychotherapy known to effectively treat major depressive disorder? (Please check all that apply)
 

☐ Yes, currently    Provider Name \_\_\_\_\_ Professional Licensure \_\_\_\_\_ Started \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ Yes, in past    Provider Name \_\_\_\_\_ Professional Licensure \_\_\_\_\_ Dates \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ No. Reasons psychotherapy, such as Cognitive Behavioral Therapy, cannot be done: \_\_\_\_\_
4. National Standardized Rating Scales administered before, weekly during and after treatment?
 

☐ Yes    Rating Scale being utilized \_\_\_\_\_

☐ No    Reason \_\_\_\_\_
5. Are any of the following conditions present?
 

☐ Seizure disorder or any history of seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

☐ Presence of acute or chronic psychotic symptoms or disorders in the current depressive episode (such as, schizophrenia or schizoaffective disorder)

☐ Neurological conditions that include history of epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

☐ Excessive use of alcohol or illicit substances within the last 30 days

☐ No response by patient to a prior course of rTMS treatments (defined as not achieving at least a 50% reduction in severity of scores for depression in a standardized rating scale, i.e. PHQ-9, by the end of acute phase treatment)

☐ The patient has received a separate acute phase rTMS treatment in the past 6 months

☐ None of the above are present.

I accept whatever number of units/days the clinical team determines is medically necessary and appropriate based on clinical submitted. Yes ☐ No ☐

Signature \_\_\_\_\_ Date \_\_\_\_\_

