Transcranial Magnetic Stimulation (TMS) treatment request

Please use the self-service portal at **HumanaMilitary.com** for TRICARE referrals. If internet is not available, fax to (877) 378-2316.

Instructions: Please complete all the fields on the treatment request form. Please use the checklist when submitting TRICARE referrals through the self-service portal at **HumanaMilitary.com** to ensure that all necessary clinical information is included and to expedite authorization process.

History of evaluation (e.g., BDI) and psychotherapy:

- Evaluation/psychotherapy type
- Date
- Frequency
- Status (current/discontinued and why)

History of TMS? If so, please provide the following information:

- Initial TMS request or concurrent continued treatment TMS
- Response to treatment
- Date
- Frequency
- Lead placement: Unilateral or bilateral

List and describe trials of failed antidepressants:

- Name of medication
- Classification (SSRI, SNRI, TCA, MAOI, etc.)
- Duration
- Dosage
- Response to medication

Describe the desired observable outcomes and indicate beneficiary's agreement with treatment goals.

If any of the following are present, please indicate on the referral/authorization request:

- Neurological condition(s) (epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, head trauma, primary or secondary tumor in the CNS, etc.).
- Metal located in or around the head.
- Vagus nerve stimulator or implants controlled by physiologic signals (pacemakers, implantable cardioverter defibrillators, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, etc.).
- Past or present seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence).
- Excessive use of alcohol or illicit substances within the past 30 days.
- Severe cardiovascular disease.
- Pregnant or breastfeeding.

Indicate whether or not the treating psychiatrist is able to adequately treat acute onset of seizure.

Indicate whether or not hearing protection is provided.

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Beneficiary information

Patient name: _____

☐ M ☐ F DOB: _____ Patient ID or SSN: _____ Active Duty Service Member: ☐ Yes ☐ No

Address: _____

City: _____ State: _____ ZIP Code: _____

DoD benefit #: _____ Phone #: _____

Referring provider

Provider name: _____ TIN/NPI: _____

Military hospital or clinic/eMSM: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

Servicing provider

Facility name: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

Provider name: _____ TIN/NPI: _____

Credentials: _____ Specialty: _____

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Background information

Current psychiatric and medical conditions:

Dx (DSM-5/ ICD-10)	Onset	Description (include symptoms and treatment)

Current medication(s):

Medication	Psychotropic	Medical	Prescribing MD	PCM	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

History of evaluation (e.g., BDI, PHQ9) and psychotherapy:

Evaluation/Tx type	Date	Frequency	Status (current/discontinued and why)	Score

History of TMS: ☐ Yes ☐ No If yes, please describe: _____

Response to treatment: _____ Date: _____ ☐ Neurostar ☐ Braisway ☐ Magstim

History of ECT and/or TMS, outcomes and dates of trials: _____

Trials of failed antidepressants including classification (SSRI, SNRI, TCA, MAOI, etc.): Med compliance: ☐ Yes ☐ No

Medication	Class	Duration	Dosage	Med compliance	Response to medication

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Service request information

Anticipated start date: _____ Anticipated completion date: _____

Device requested: ☐ Neurostar ☐ Braisway ☐ Magstim Location: ☐ Inpatient ☐ Outpatient ☐ Combination

Initial TMS request (requested frequency and administration): _____

Concurrent Continued TMS request (past frequency, new frequency and duration requested): _____

CPT code	Units	Frequency	Additional comments
90867			
90868			
90869			

Desired observable outcomes: Beneficiary agrees with treatment goals: ☐ Yes ☐ No

_____

_____

_____

_____

Please respond to the following (mark all that apply):

☐ Neurological condition(s) (epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, head trauma, primary or secondary tumor in the CNS, etc.).

☐ Metal located in or around the head.

☐ Vagus nerve stimulator or implants controlled by physiologic signals (pacemakers, implantable cardioverter defibrillators, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, etc.).

☐ Past or present seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence).

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

☐ Severe cardiovascular disease.

☐ Pregnant or breastfeeding.

Is the treating psychiatrist able to adequately treat acute onset of seizure: ☐ Yes ☐ No

Hearing protection provided: ☐ Yes ☐ No

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program.

Provider signature: _____ Date: _____

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