3545 NW 58th St., Ste. 600, Oklahoma City, OK 73112
Phone 405-717-8879 or 800-543-6044, ext. 8879
Fax 405-949-5459 or 405-949-5501

Transcranial Magnetic Stimulation Request

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing provider ______________________________ Date ______________

Billing address ____

TIN ______________________________ Contact person ______________

Phone ______________________________ Fax ______________

Patient ______________________________ DOB ______________

Member ______________________________ Member ID ______________

ICD-10 diagnosis codes ____

Has patient received prior TMS? No ☐ Yes ☐ If yes, list dates ______________

Has patient received prior ECT? No ☐ Yes ☐ If yes, list dates ______________

Are any of the following present? Alcohol or drug use ☐ Metal implant in or around head ☐ Implanted devices ☐
Suicidal ideations ☐ Neurological condition ☐ Seizure disorder ☐ Psychosis ☐ Severe cardiovascular disease ☐

Current symptoms ____

____

____

Psychotherapy — Is this patient currently in cognitive behavioral therapy? No ☐ Yes ☐

Name of outpatient therapist and list credentials ______________________________

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History of psychotherapy ____

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What standardized depression rating scale was administered? ______________________________

Date and result of test ____

History of inpatient/residential/PHP/IOP admissions ______________________________

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Medication Trials

Antidepressants — Trials of at least **four** different antidepressants from a minimum of **two** different classifications.

Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

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Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

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Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

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Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

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Other Medications

Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

____

Medication ______________________ Date of trial ____________________ Duration of trial ___________________

Outcome/Side Effects ____

____

Treatment

CPT code 90867 number of treatments ____________ Start date ________________ Stop date ________________

CPT code 90868 number of treatments ____________ Start date ________________ Stop date ________________

CPT code 90869 number of treatments ____________ Start date ________________ Stop date ________________

Signature ___________________________________ Date ______________________________________

**** All information is required for review. Information provided is private and confidential. ****

NOTE: These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator toll-free at 800-323-4314.

MEDICARE PATIENTS: If HealthChoice is the supplemental insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.