



# TMS (Transcranial Magnetic Stimulation) Treatment Authorization Request

Use only for Commercial LOB

Standard fax number: (844) 742-1155

Urgent fax number: (844) 729-1416

Use AuthAccel, Blue Shield of California's online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection ([blueshieldca.com/provider](https://blueshieldca.com/provider)) and click the *Authorizations* tab to get started.

**Blue Shield has a five business day turnaround time on all standard prior authorization requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.**

Important for urgent requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to severe pain, potential loss of life, limb, or major bodily function, and a delay in decision-making might seriously jeopardize the life or health of the enrollee. If there is no MD signature present, the request will be processed as a standard request.

MD signature REQUIRED for urgent requests only:

Type of request: ☐ New standard request ☐ Retro request ☐ Urgent request

**If you are submitting a modification or extension, check one, and complete the details below:** ☐ Modification request ☐ Extension request

Previous authorization number:

Current last authorized day:

New authorization end date:

Provider justification for modification or extension:

## Patient information

First name:

Last name:

Date of birth (DOB):

Blue Shield subscriber ID number:

Street address:

City:

Home phone:

State:

ZIP code:

Cell phone:

Primary: ☐ Home ☐ Cell

Require interpreter: ☐ Yes ☐ No ☐ American Sign Language

## Requesting provider

Provider first name:

Provider last name:

Group name:

Group tax ID:

Group NPI:

Specialist type:

Street address and suite number:

City:

State:

ZIP code:

Phone number:

Fax:

## Servicing/rendering provider

**If same as requesting provider, check ☐**

Provider first name:

Provider last name:

Group name:

Group tax ID:

Group NPI:

Specialist type:

Street address and suite number:

City:

State:

ZIP code:

Phone number:

Fax:

**Place of service (check one box only):**

☐ Office ☐ Other (please specify) \_\_\_\_\_

**CPT/HCPC code(s):**

Procedure code	90867	90868	90869	0890T	0891T	0892T	0889T
Number of visits							
Frequency							

Diagnosis:

ICD-10 code(s):

**\*\*\*See patient clinical information box below for required documentation\*\*\***

Requested start date of authorization:

Contact name:

Contact fax number:

Contact phone:

Is the voicemail confidential: ☐ Yes ☐ No**Patient clinical information****Please provide the following documentation:**

History and physical and/or consultation notes including:

- Reason(s) for treatment and qualification of treatment resistant Major Depressive Disorder. Include standardized rating scales for depression (for example PHQ-9 score) with date completed.
- Report of antidepressants and/or augmentation medication trials during current depressive episode. Include dose, start/end dates, and response.
- Current medications including dosages, start/end date, and response.
- Report of psychotherapy trials during current depressive episode. Include modality, frequency, start/end dates, and response.
- Report of previous TMS treatment. Include modality, number of sessions, start/end dates, and response (including first and last standardized rating scale).
- Document the absence of all contraindications. If member has a relative contraindication, document medical clearance and plan of action.
- Type and regimen/protocol of TMS planned for use.

Post service (in addition to the above, please include the following):

- Progress notes and/or reports by attending physician evaluating patient response to TMS therapy.
- Type and regimen/protocol of TMS used.

If you have questions, please call Blue Shield Promise Behavioral Health Treatment Program at (888) 297-1325.

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