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Aetna Better Health® of Illinois

Outpatient Behavioral Health (BH) Request – TMS Requests: Transcranial Magnetic Stimulation Precertification Information Request

Do not use for extension requests.

Fax to: Behavioral Health Precert	**Portal:**
• Medicaid: **1-844-528-3453**	**www.Availity.com**

Please complete all fields and write legibly.

Section 1 (TO BE FILLED OUT BY INTAKE STAFF OR PROVIDER STAFF)

Member name:	Member telephone number: - -
Member ID:	Member date of birth:
Facility, Physician, Provider or Vendor name:	
Facility, Physician, Provider or Vendor address:	
Facility, Physician, Provider or Vendor telephone number:	Facility, Physician, Provider or Vendor NPI :
Provider Specialty:	Provider TIN:
Facility, Physician, Provider or Vendor fax number 1 - - -	

Section 2 – Provide the following general information

Name, specialty, and degree of provider who evaluated the member, reviewed their record and ordered TMS:

Was this evaluation face to face? ☐ Yes ☐ No, please explain:

Current Behavioral Health diagnosis code(s)current:

Please note any historical Behavioral Health diagnosis that differ from above:

Planned start date of TMS services:	**Select the CPT/HCPCS codes** which best describe the service(s) you will provide and indicate the number of sessions requested: ☐ **90867** _____ ☐ **90868** _____ ☐ **90869** _____ ☐ **Other:** _____

Section 3 – Provide the following patient-specific information

1. Presenting problems and symptoms:

2. Date current episode began:

3. Validated rating scales that support the diagnosis:
Rating scale(s) Name, Date, and Score: _____

_____

_____

4. Is there a history of TMS treatment? If yes:

- **Starting score and date (before treatment):**
  Score: _____ Date: _____
- **Ending score and date (after treatment):**
  Score: _____ Date: _____

List the treatment approaches (psychotherapy/ pharmacologic therapy) used to maintain treatment effect

5. Check any of the following that currently exist:

- ☐ High alcohol or illicit drug consumption
- ☐ Metal fragments or implants in or around the head within 30 cm of coil
- ☐ Tattoos in the head or neck made with ferromagnetic-containing ink
- ☐ Member currently receiving ECT
- ☐ Seizure disorder/epilepsy
- ☐ Cardiovascular disease
- ☐ Neurological condition
- ☐ Other implants (e.g. pace maker etc.)
- ☐ **Other** _____
- ☐ Acute suicidal risk
- ☐ Psychosis
- ☐ Catatonia

6. If yes to any of the above, please explain and provide the the name and degree and specialty of the provider that cleared the member for TMS:

7. If yes to alcohol or Illicit drug use, please note what substances are used, the amount and frequency, dates of last use.

Section 3 continued on the next page.

Section 3 – Provide the following patient-specific information

8. Document **ALL** psychopharmacologic trials (with augmenting agents) during the **CURRENT** episode**. Must Include the full dates, doses and outcome of each trial.**

Medication	**Dosage**	Dates (**month/day/year**)	Results of Medication Trials/Side Effects that limited dosing	Primary or Augmenting Medication (if augmenting, indicate which antidepressant it is augmenting)
		Start:		
		Stop:		
		Start:		
		Stop:		
		Start:		
		Stop:		
		Start:		
		Stop:		
		Start:		
		Stop:		

Section 4 – Additional comments

Do you have any additional clinical information you would like to report regarding this request?

Section 5 – Read this important information

Please send in any additional clinical

Section 6 – Sign the form

Form completed by	**Title/Date**