TMS Preauthorization Request

DATE	INSURED'S EMPLOYER		
PATIENT LAST NAME	FIRST NAME	DATE OF BIRTH	AGE

PROVIDER INFORMATION:

PSYCHIATRIST	PHONE	FAX	NAME OF PRACTICE
PRIMARY CONTACT	PHONE	FAX	REFERRING PHYSICIAN

DSM-5 DIAGNOSIS:

1. _____ 3. _____
2. _____ 4. _____

PRIOR TMS?

Yes ☐ No ☐

Date Completed: _____

CURRENT PSYCHOTROPIC MEDICATIONS? Yes ☐ No ☐

If Yes, list all including dose and start date:

1. _____ 3. _____
2. _____ 4. _____

TREATMENT RESISTANT DEPRESSION? Yes ☐ No ☐

If Yes, check all medication trials that apply:

1. Antidepressant ☐
2. Antidepressant, Different Class ☐
3. Antidepressant with Augmentation ☐
4. Other: _____ ☐

For **EACH** medication prescribed at the **maximum recommended dose,** the following **must be** provided to document Treatment Resistant Depression:

	Medication Name:	Prescribed Dose:	Number of Weeks Maximum Dose Taken:
1.			
2.			
3.			
4.			
5.			

PSYCHOTHERAPY? Yes ☐ No ☐

THERAPIST'S NAME:	DATES OF TREATMENT:
1. _____	From: _____ To: _____
2. _____	From: _____ To: _____

CURRENT TMS AUTHORIZATION REQUEST:

TMS START DATE	NUMBER OF TREATMENTS REQUESTED WITH THIS AUTHORIZATION	REQUESTED FREQUENCY
NUMBER OF TREATMENTS RENDERED TO DATE	ANTICIPATED TOTAL NUMBER OF TREATMENTS	

If TMS has already started, provide a brief summary of the patient's response to TMS to date:

_____

_____

_____ _____

Physician Signature **Date**

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