1199SEIU Benefit Funds

498 Seventh Avenue, 3rd Floor, New York, NY 10018-0009 • Tel: (646) 473-6868 • Fax: (646) 473-6919 • www.1199SEIUBenefits.org • @1199SEIUBenefits

TRANSCRANIAL MAGNETIC STIMULATION (TMS) PRE-AUTHORIZATION FORM

This form is fillable: You can type in your information. Complete the form and attach copies of pertinent medical documents or copies of the physician's actual office chart to support your request. Fax the completed form, with supporting documents, to (646) 473-6919.

NOTE: Any sections that are not filled out will be considered not applicable to your patient, AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

MEMBER'S FULL NAME (FIRST AND LAST NAME) MEMBER ID #

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL PHONE

EMAIL ADDRESS *(Providing your email address is optional. If you choose to provide it, you allow the Benefit Funds to contact you by email.* Note: *Communications over the Internet may not be secure.)*

PATIENT INFORMATION *(if not the member)*

PATIENT'S FULL NAME (FIRST AND LAST NAME) SOCIAL SECURITY #

DATE OF BIRTH (MM/DD/YYYY) Gender ***(choose one):*** ☐ Male ☐ Female CELL PHONE

EMAIL ADDRESS *(Providing your email address is optional. If you choose to provide it, you allow the Benefit Funds to contact you by email.* Note: *Communications over the Internet may not be secure.)*

CPT/HCPCS CODE(S) – TO PROCESS YOUR REQUEST, THE CPT/HCPCS CODE(S) *MUST* BE PROVIDED.

CODE(S)

DESCRIPTION(S)

ICD-10 CODE(S) – TO PROCESS YOUR REQUEST, THE ICD-10 CODE(S) *MUST* BE PROVIDED.

PRINCIPAL CODE

DESCRIPTION

SECONDARY CODE

DESCRIPTION

WELTMS • 07/22 • TMS PRE-AUTHORIZATION

TMS INFORMATION FOR PRE-AUTHORIZATION

PROPOSED START DATE OF TMS (MM/DD/YYYY) APPROXIMATE DATE OF ONSET OF SYMPTOMS OF CURRENT EPISODE (MM/DD/YYYY)

Presenting problems and symptoms: ______

DEPRESSION-RATING INSTRUMENT USED (PLEASE ALSO ATTACH VALIDATED MONITORING SCALE)

PAST HISTORY OF TMS TREATMENT (LIST IN ORDER OF MOST RECENT TO OLDEST)

(Please also attach clinical evidence of improvement, with standard rating scales for depressive symptoms.)

START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)	PRE-SCORE	POST-SCORE

Does the patient have a history of substance abuse? ☐ No ☐ Yes

If yes, please explain:

Does the patient have a history of seizures? ☐ No ☐ Yes

If yes, how have they been addressed?

Does the patient have ferromagnetic or other magnetic-sensitive metal implants with 30 cm. of the TMS coil? ☐ No ☐ Yes

Was psychotherapy used during this current episode? ☐ No ☐ Yes

If yes, please indicate:

PROVIDER	SPECIALTY	TYPE OF THERAPY	DATES OF THERAPY	FREQUENCY	EFFECTIVENESS

Are there any risks or concerns, including suicidal or homicidal ideation or self-injurious behavior? ☐ No ☐ Yes

If yes, please explain: ______

LIST PATIENT'S MEDICATION TRIALS DURING CURRENT EPISODE: (include all augmentation agents utilized)

NAME OF MEDICATION	CLASS OF MEDICATION	MAXIMUM DOSE	START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)	RESPONSE, SIDE EFFECTS OR REASON FOR DISCONTINUATION

PHYSICIAN INFORMATION – TO PROCESS YOUR REQUEST, THE PHYSICIAN'S TAX ID AND FAX NUMBERS *MUST* BE PROVIDED.

TMS PHYSICIAN'S FULL NAME (FIRST AND LAST NAME)

PHYSICIAN'S SPECIALTY | TIN (TAX ID NUMBER)

PHYSICIAN'S PHONE NUMBER | FAX NUMBER

PHYSICIAN'S STREET ADDRESS | CITY | STATE | ZIP CODE

REFERRING PHYSICIAN'S FULL NAME (FIRST AND LAST NAME) | REFERRING PHYSICIAN'S SPECIALTY (IF DIFFERENT FROM ABOVE PHYSICIAN)

REQUEST SUBMITTED BY | REQUEST DATE (MM/DD/YYYY)

CURRENT TREATING PSYCHIATRIST | PSYCHIATRIST'S PHONE NUMBER

PSYCHIATRIST'S STREET ADDRESS | CITY | STATE | ZIP CODE

FAX THE COMPLETED FORM, WITH SUPPORTING DOCUMENTS, TO (646) 473-6919.

This pre-authorization request is a claim for plan benefits as defined by 29 CFR § 2560.503-1. The Funds' pre-authorization determination is not a guarantee of payment, and is not a contract. The patient's right to reimbursement is governed exclusively by the Funds' plan documents.

The Funds' Pre-Authorization Call Center is available Monday through Friday, 9:00 am to 5:00 pm at (646) 473-6868.

Our pre-authorization requirements are subject to change; periodically visit **www.1199SEIUFunds.org** and click on the "For Providers" section for our most recent pre-authorization requirements, forms and other information.