Request for Authorization: Transcranial Magnetic Stimulation

New York | Medicare Advantage • Commercial

Instructions: Please submit this form electronically at **https://www.Availity.com**.

Member information	
Today's date:	
UM number (if received):	
Name:	
ID number:	
Date of birth:	
Current age:	
Complete address (including city, state, and ZIP):	
Phone number:	

Provider information	
Physician name (MD, DO, NP):	
Phone number:	
TMS coordinator name:	
Phone number:	
Fax number:	
Email address:	
Complete address (including city, state, and ZIP):	
Provider NPI:	
Tax ID number:	

Medicare coverage provided by Anthem Blue Cross and Blue Shield, trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc., Anthem Blue Cross and Blue Shield HP, trade name of Anthem HP, LLC., or Anthem Blue Cross and Blue Shield Retiree Solutions, trade name of Anthem Insurance Companies, Inc. Commercial coverage provided by Anthem Blue Cross and Blue Shield, trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc., or Anthem Blue Cross and Blue Shield HP, trade name of Anthem HP, LLC.
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NY-BCBS-CRCM-018948-26-GRP4931 | September 2026

CPT® codes	Requested start date	Number of sessions/units
90867 — Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management		
90868 — Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session		
Additional code(s) —		

Complete the following information in its entirety.	Yes/no
Is request for repetitive transcranial magnetic stimulation (rTMS) of the brain using frequencies ≤ 1 Hz OR 5-20 Hz? Specify protocol:	
Is request for TBS of the brain using high-frequency (50-Hz) triple burst on a theta cycle? Specify protocol:	
Is request for bilateral rTMS?	
If yes, has a unilateral treatment course been completed?	
Is treatment for severe major depressive disorder (MDD)? Diagnosis code: Standardized rating scale used: Initial score (most recent index): Date: Most recent/current score: Date:	
Does individual have current or a history of psychotic symptoms or psychotic disorder? Diagnosis code(s)/symptoms:	
Does individual have a seizure disorder or history of seizures? List disorder(s) here:	
Does individual have a neurological condition? List condition(s) here:	
Does individual have any other medical or mental health diagnosis? List here: Standardized rating scale used: Initial score (most recent index): Date: Most recent/current score: Date:	

Complete the following information in its entirety.	Yes/no
Is individual currently taking any benzodiazepines (for example, Xanax®, Klonopin®, Valium®)? Specify medication and dose:	
Has individual attempted psychotherapy for MDD? Modality used (for example, cognitive behavioral therapy, interpersonal psychotherapy, behavioral activation):	
Does individual have implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items? **Note: Dental amalgam fillings are acceptable for use with TMS.** List device here:	
Will an FDA-approved TMS device be used? Name of device:	
Has individual received prior TMS or TBS treatment?	
Is individual currently receiving TMS/TBS?	
Was last TMS/TBS session greater than or equal to 6 months ago?	
Is this request for maintenance TMS/TBS? *Maintenance means scheduled or periodic TMS treatments provided after a successful acute course to sustain clinical response and reduce risk of relapse, in the absence of a current qualifying episode.	
Has individual achieved full remission of symptoms currently or in the past from TMS/TBS? *Full remission is defined as not meeting criteria for MDD for 2 months or more.	
If no, has the individual achieved a 50% or greater reduction in symptoms from TMS, currently or in the past? *This should be based on standardized scoring.	

For the current or previous episode of depression, list the medication trials.				
Medication — antidepressants	**Maximum dose**	**Duration of trial on maximum dose**	**Adherence yes/no**	**List discontinued reason (ineffective, intolerable side effects, or ongoing prescription)**
				List side effects:

For the current or previous episode of depression, list the medication trials.				
				List side effects:
				List side effects:
				List side effects:
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				List side effects:
				List side effects:

You may also submit any additional information relevant to your request for authorization, such as a copy of the TMS intake evaluation or any full psychiatric evaluation conducted within a three-month period prior to the requested start of treatment.

By signing below, you are confirming the information you have provided on this form is accurate and complete based on your clinical assessment of the patient and the records available to you as of the date of this request.

Physician's name (print): _____

Physician's signature: _____

Date: _____

If unable to submit your request via Availity Essentials, you may fax this completed form to **844-430-1703** (Medicare) or **888-479-6431** (Commercial).