blue of california

| Prior Authorization Request Form | Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders |
|---|---|
| **Standard Fax Number:** 1 (844) 807-8997 | **Urgent Fax Number:** 1 (844) 807-8996 |

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

**Notice: Blue Shield of CA has a 5 Business Day turn-around 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.**

☐ New Standard Request ☐ New Urgent Request ☐ Standing Referral

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:*

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

| Date Last Authorized: | Previous Authorization Number: |
|---|---|
| MD/NP/PA justification for modification or extension: | |

**Patient Information:**

| First Name: | Last Name: |
|---|---|
| Date of Birth: | ID Number: |
| Address: | |

**Referring/Prescribing Provider:**

| Name: | | | NPI: | |
|---|---|---|---|---|
| Street Address + Suite #: | | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Type of Provider: ☐ PCP ☐ Specialist Type: | | | Contact Name and Phone Number: | |

**Servicing/Billing: Provider/Vendor/Lab** *If same as Referring/Prescribing Provider Check Here* ☐

| Name: | Tax ID: | NPI: |
|---|---|---|
| Street Address + Suite #: | | |

| City: | State: | Zip: | Phone: | Fax: |
|---|---|---|---|---|
| Specialist Type: | | | Contact Name and Phone Number: | |

**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:**

| Group Name: | | NPI: |
|---|---|---|
| Street Address + Suite #: | | |
| City: | State: | Zip: |

**Billing Facility (If Applicable):**

| Facility Name: | | NPI: | |
|---|---|---|---|
| Street Address + Suite #: | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Contact Name and Phone Number: | | | |

| **Anticipated Date of Service:** | **If Lab, Draw Date:** |
|---|---|

**Place of Service: (Check One Box Only or If typing replace box with an "X"):**

| | | |
|---|---|---|
| ☐ Office | ☐ Home | ☐ On Campus OP Hosp |
| ☐ Acute Rehab | ☐ Hospice | ☐ PH |
| ☐ Ambulance- Air or Water | ☐ Independent Clinic | ☐ RTC – Psychiatric |
| ☐ Ambulance-Land | ☐ Independent Laboratory | ☐ RTC – SUD |
| ☐ Ambulatory Surgical Center | ☐ Inpatient Hospital | ☐ Skilled Nursing Facility |
| ☐ Assisted Living Facility | ☐ Intermediate Care Facility | ☐ Telehealth |
| ☐ Birthing Center | ☐ IOP | ☐ Urgent Care Facility |
| ☐ Custodial Care Facility | ☐ IP Psychiatric Facility | ☐ Other - Please Specify: |
| ☐ End Stage Renal Disease Tx | ☐ Nursing Facility | |
| ☐ Group Home | ☐ Off Campus OP Hosp | |

**Please enter all codes requested; unlisted codes must have a description.**
**Please include the quantity for each code requested and if applicable, left, right or bilateral designations.**

ICD-10 Code(s):

CPT/HCPC Code(s):

**For questions: Call BSC Medical Care Solutions Phone Number: 1-800-541-6652**

**Please provide the following documentation:**

- ☐ History and physical and/or consultation notes including:
  - ☐ Reason(s) for therapy and qualification of severe major depressive disorder using standardized rating scales
  - ☐ Report of patient response and/or intolerance to 4 psychopharmacologic agents
  - ☐ Any previous response to rTMS if applicable
  - ☐ Documented absence of any contraindication (i.e., seizure disorders, acute or chronic psychosis, neurologic conditions, implanted magnetic-sensitive medical devices)
  - ☐ Type and regimen/protocol of rTMS planned for use

Visit our website at blueshieldca.com