Patient Enrollment Form

The purpose of this form is to obtain volunteered information about a potential patient candidates, their healthcare provider, and any other relevant information to determine if insurance coverage is possible. The information on this form must be volunteered by the patient and consented to be shared for the purpose of determining if they have insurance information.

PLEASE FAX OR SCAN/EMAIL COMPLETED FORM ALONG WITH ANY SUPPORTING INFORMATION TO:

FAX: 844-332-3897

EMAIL: info@BrainswayReimb.com

For Live Assistance Call: (844) 333-7867 / (844) DEEPTMS

Date Submitted: ____/____/____

Provider Information			
Contact Person:	Title:		
Prescribing Physician Name:	Practice Name:		
Street Address:	City:	State:	ZIP Code:
Phone Number:	Fax Number:		
Email Address:	Preferred Contact Method: ☐ Phone ☐ Fax ☐ Email		
NPI Number:	Tax ID Number:		

Patient Information (U.S. Residents Only)				
Patient's Name:	Patient's Phone Number:	Sex: ☐ M ☐ F		Date of Birth:
Street Address:	City:		State:	ZIP Code:

Insurance Information (Submit Copy of Insurance Card)		
Primary Insurance Company Name:		Insurance Phone Number:
Plan Type: ☐ HMO ☐ PPO ☐ Commercial ☐ Medicare ☐ Medicaid		
Member ID Number:	Group Number:	Policy Holder:
Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		
PLEASE ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD		

Medical History

Patient Information
Name_______________________________
Date of birth____/____/________
Member ID# _________________________
Treating TMS Facility__________________

Medical History
Primary diagnosis code (ICD-10) _________________
Date of diagnosis____/____/_______
Additional diagnosis code (if applicable)____________
Date of diagnosis____/____/_______
Additional medical conditions___________________

Requested CPT
please check the relevant codes for treatment:
☐ **90867**- initial treatment
☐ **90868**- Subsequent delivery and management, per session
☐ **90869**- Subsequent MT re-determination with delivery and management

Pharmacotherapy History
Most payers require clearly documented antidepressant treatment history to show the patient has failed to respond to at least four (4) drug trials from at least two (2) different class agents at minimal dose and duration (including augmentation) or could not tolerate four medication trails due to side effects

Trial #	Antidepressant Medication (Use both lines in case of augmentation)	Class SSRI,SNRI, TCA, MAOI, other	Max. dose	Duration at max. dose	Date last prescribed	Prescribing physician	Detailed side effects (if reported)	Trial successful?
1					___/___/_____			□Yes □No
					___/___/_____			
2					___/___/_____			□Yes □No
					___/___/_____			
3					___/___/_____			□Yes □No
					___/___/_____			
4					___/___/_____			□Yes □No
					___/___/_____			
5					___/___/_____			□Yes □No
					___/___/_____			

What Standardized Rating scale was the patient evaluated with?

☐PHQ-9 ☐QIDS-SR ☐HDRS-21 ☐BDI-II ☐ other:______________Date last administered / /____score______ Administered by (if applicable): ________________

Medical History

General Medical Condition Questionnaire

Are any of the following conditions present in the patient?
Check all relevant:

- ☐ recently attempted suicide or ideated suicide
- ☐ has acute or chronic psychotic symptoms or disorders (e.g., schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode
- ☐ has bipolar disorder
- ☐ has a history of substance abuse or has used alcohol or illicit substances excessively in the last 30 days
- ☐ has a history of obsessive compulsive disorder (OCD) or post-traumatic stress disorder (PTSD)
- ☐ has major depressive disorder with psychotic features
- ☐ has neurological conditions that include epilepsy history, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system
- ☐ has metal implants in or around the head
- ☐ has a Vagus Nerve Stimulator (VNS) or other implant controlled by physiologic signals (such as pacemakers, implantable cardioverter defibrillators)
- ☐ is pregnant or nursing

Type of Behavioral Therapy		Provider Name	Prof. Licensure	Initiation date	End date
Psycho-therapy	Current			/ /_____	
	Previous			/ /_____	/ /_____
Cognitive Behavioral Therapy	Current			/ /_____	
	previous			/ /_____	/ /_____

ECT History

Has the patient been treated with ECT in a previous depressive episode? ☐Yes ☐No.

If yes, was the treatment successful? ☐Yes ☐No

Is the patient a candidate for ECT and has declined ECT treatment? ☐Yes ☐No

Has the patient been treated with ECT in the current episode? ☐Yes ☐No

If yes: No. of sessions_______ Diagnostic scale used____

Score pre-treatment________date / /__
Score post-treatment________date / /_

TMS History

Has the patient been treated for depression with TMS in a previous depressive episode? ☐Yes ☐No

If yes, what system? ☐ Neurostar ☐Brainsway
No. of sessions_______ Diagnostic scale used_____

score pre-treatment______date / /___score post-treatment_______date / /___

Disclaimer: The Brainsway Reimbursement Support Program does not make any representations or warranties regarding payment, and there are no guarantees of payment by any payer. It is the absolute and sole responsibility of the provider to ensure that appropriate claims and charges for services rendered are submitted. In the event that a favorable coverage determination is not achieved, Brainsway is not and shall not be liable for any cost whatsoever, including those costs related to the patient's medical treatment.

FAX: 844-332-3897
EMAIL: info@BrainswayReimb.com
For Live Assistance Call: (844) 333-7867 / (844) DEEPTMS