

**Brainsway Reimbursement Support Program: Patient Information Form**

The purpose of this form is to gather volunteered information about a potential patient candidates, their provider and any other relevant information to determine if insurance coverage is possible. A separate authorization is not required as we are fully HIPAA compliant and are serving in the capacity of obtaining insurance coverage. If you would prefer to have the patient sign a release, there is one available upon request.

**Please fax or scan/email completed form along a copy of the front and back of the patient’s insurance cards with any supporting information to:**

**FAX: 1-(844) 332-3897**

**info@BrainswayReimb.com**

For Live Assistance Call: **1-(844) 333-7867, 1(844) DEEP TMS**

**Date Submitted: \_\_\_\_/\_\_\_\_/\_\_\_\_**

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| **Provider Information** | | | | |
| Contact Person: | | Title: | | |
| Prescribing Physician Name: | | Practice Name: | | |
| Street Address: | | City: | State: | ZIP Code: |
| Phone Number: | | Physician Board Certification or Specialty: | | |
| Email Address: | | Fax Number: | | |
| NPI Number: | Tax ID Number: | Preferred Contact Method:  □ Phone □ Fax □ Email | | |

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| **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: |

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| **Insurance Information** | | |
| Primary Insurance Company Name: | | Insurance Phone Number: |
| Member ID Number: | Group Number: | Policy Holder: |
| Policy Holder Relationship to Patient:  Self  Spouse  Child  Other | | |

Date **current episode** of depression began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*\*Medication trials should only be listed for the **current** episode\*\*)

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| **Medical History and Coverage Eligibility** |
| Most payers require clearly documented **antidepressant** 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 trials due to side effects **IN THE CURRENT EPISODE OF DEPRESSION**. Some require **two (2) augmentation medications** as well.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Trial # | Anti-depressant Medication | Max Dose | Start and Stop Date of medication trial | Lack of effect or side effect? | Detailed side effects (if applicable) | | 1 |  |  |  | LOE  S/E |  | | 2 |  |  |  | LOE  S/E |  | | 3 |  |  |  | LOE  S/E |  | | 4 |  |  |  | LOE  S/E |  | | 5 |  |  |  | LOE  S/E |  | | 6 |  |  |  | LOE  S/E |  | | 7 |  |  |  | LOE  S/E |  | | 8 |  |  |  | LOE  S/E |  | |

When payers review failure of medications, they deem the failure either a “lack of effect” or “undesired side effect”

* If lack of effect, the medication must have been a maximum dose and used for 16 weeks or longer.
* If the patient has a side effect, the dosage and duration doesn’t matter. The side effect MUST be documented. The definition of side effect is that it caused a situation that the patient couldn’t tolerate

(allergy, migraines or uncontrolled headaches, incontinence, impotence….)

BRIEF clinical update and symptoms of depression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Diagnosis (s) (CIRCLE ONE):**

F32.2-MDD, severe, single episode, without psychotic features.

F33.2-MDD, severe, recurrent episode, without psychotic features.

**Additional Medical Questions:**

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| **Question** | **Answer:** |
| How often will the patient see the psychiatrist? |  |
| What standardized rating scale was used?   * What was the score? * Who administered? * Date of most recent scale? | ☐PHQ-9 ☐ QIDS-SR ☐HDRS-21 ☐BDI-II |
| Does the patient exhibit any non-psychiatric medical conditions? If so, what are they? | ☐Yes ☐No |
| Any neurological disorders? If so, what are they (such as seizures)? | ☐Yes ☐No |
| Does the patient have a history of any of these? | Obsessive Compulsive Disorder ☐Yes ☐No  Psychotic Disorder ☐Yes ☐No  Bipolar Disorder ☐Yes ☐No  Psychotic Disorder ☐Yes ☐No  Post-Traumatic Stress Disorder ☐Yes ☐No |
| Any suicidal ideation? | ☐Yes ☐No |
| Does the patient have any history of substance abuse? | ☐Yes ☐No |
| Is there a history of ECT or TMS therapy? If so,  Beginning date and rating scale score:  Ending date and rating scale score: | ☐Yes ☐No  Date:\_\_\_\_\_\_\_\_\_\_\_ Rating scale:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score:\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_ Rating scale:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score:\_\_\_\_\_ |
| Does the patient have metal in or around the head? | ☐Yes ☐No |
| Does the patient have a Vagus Nerve Stimulator? | ☐Yes ☐No |
| Has the patient been assessed for ECT and found to be a candidate, but declined due to unwanted side effects?  Has this information been documented in the medical record as such? | ☐Yes ☐No  ☐Yes ☐No |
| Has the patient has either Psychotherapy or Cognitive Behavioral Therapy IN THE CURRENT DEPRESSIVE EPISODE? Please list as much info as possible. The payers typically want to know the frequency, duration and type of therapy. | Modality of therapy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stop Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of sessions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |