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: ____/____/____

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		

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

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

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	Duration at Max Dose	Dates used	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.

Date **current episode** of depression began: _____
(**Medication trials should only be listed for the **current** episode**)

Additional Medical Questions:

Question	Answer:
How often will the patient see the psychiatrist?	
What method will be used to monitor progress through the course of therapy? Algorithm used?	
What standardized rating scale was used? • What was the score? • Who administered? • Date of last test?	☐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, what was the **outcome**?	☐Yes ☐No
Is the patient pregnant or nursing?	☐Yes ☐No
Does the patient have metal in or around the head?	☐Yes ☐No
Does the patient have a Vagus Nerve Stimulator?	☐Yes ☐No
How many of each code is needed for a full course of therapy?	90867 – ONE (1) 90868 –THIRTY THREE (33) 90869 –TWO (2)
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.	☐ Psychotherapy Current Start Date: _____ Frequency of sessions: _____ Provider/therapist: _____ ☐ Cognitive Behavioral Therapy Current Start Date: _____ Frequency of sessions: _____ Provider/therapist: _____