BrainsWay MDD

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BRAINSWAY MDD REIMBURSEMENT SUPPORT PROGRAM: PATIENT INFORMATION FORM

The purpose of this form is to gather volunteered information about a potential patient candidate, 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, a copy of the front and back of the patient's insurance cards, and any supporting info to:

FAX: 844-332-3897 | EMAIL: info@BrainsWayReimb.com

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

signifies a required field Expected Treatment Date: ______________ Date Submitted: ______________

TREATING PROVIDER INFORMATION

Contact Person:	Title:	
*Provider Name:	*Provider NPI Number:	
*Practice Name:	*Practice NPI Number:	
*Street Address:		
*City:	*State:	*ZIP Code:
*Board Certification/Specialty:	Email Address:	
*Phone Number:	*Fax Number:	
*Tax ID Number:	*Preferred Contact Method: Phone Fax	

REFERRING PROVIDER INFORMATION

Same as Treating Provider

Referring Provider Name:	Phone Number:
NPI Number:	Practice Name:

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

PATIENT INFORMATION

Patient Name:	Date of Birth:

MEDICAL HISTORY AND COVERAGE ELIGIBILITY

Most payers require clearly documented antidepressant history to show the patient has, IN THE CURRENT EPISODE OF DEPRESSION, failed to:

- Respond to at least **four (4) medication trials** from at least **two (2) different class agents** at minimal dose and duration (including augmentation) OR
- Could not tolerate f**our (4) medication trials** due to side effects

Some require t**wo (2) augmentation medications** as well.

Date **Current Episode** of Depression Began: ________________
*Medication trials should only be listed for the **current** episode

Trial #	*Medication	*Max Dose	*Start Date	*Stop Date	*or Currently Taking	*Lack of Effect (LOE) or Side Effect (S/E)	*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 INFORMATION

Patient Name:	Date of Birth:

*Patient Diagnosis (CHECK ONE):

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

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

Other: ____

*Additional Medical Questions:

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?	
*List any comorbid psychiatric diagnoses	
*List any non-psychiatric medical conditions	
*List neurological conditions increasing seizure risk	
*Any suicidal plans or intent?	Yes No
*Did the patient have substance use disorder in the last six months?	Yes No
*Is there a history of ECT or TMS therapy for depression? If so,	Yes No
Beginning date and rating scale score:	Date: _______________ Rating scale: _________________ Score: ______
Ending date and rating scale score:	Date: _______________ Rating scale: _________________ Score: ______
*Is the patient pregnant or nursing?	Yes No
*Does the patient have ferromagnetic material within 10cm of the coil?	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 *Initial treatment* ____ 90868 *Subsequent delivery and management, per session* ____ 90869 *Subsequent MT re-determination with delivery and management* ____
*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 had Psychotherapy (e.g. CBT) for MDD in the current depressive episode? Please list as much info as possible. The payers typically want to know the frequency, duration and outcome. Also please note if the patient is unwilling to participate in CBT or if it is not available in their area by a covered provider.	Modality of Therapy: ______________________ Provider: ______________________ Start Date: ______________________ Stop Date: ______________________ Current Frequency: ______________________ Total Number of Sessions: ______________________