BrainsWay OCD

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BRAINSWAY OCD 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

Payers may require clearly documented treatment history to show the patient has failed to respond or could not tolerate four medication trials due to side effects.

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 used at a therapeutic dose for 8-13 weeks or longer
- If the patient has a side effect, the dosage and duration doesn't matter, but the specific 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….)
- If the patient is currently taking the medicine, there must still be residual symptoms. Please detail these symptoms below and include the Yale-Brown Obsessive Compulsive Scale (YBOCS)

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	CBT for OCD/ERP	#sessions			☐	☐ LOE ☐ S/E	

*BRIEF clinical update and symptoms of obsessions, compulsions, avoidances:

PATIENT INFORMATION	
Patient Name:	Date of Birth:

*Patient Diagnosis (CHECK ONE):

☐ F42.2 Mixed Obsessional Thoughts and Acts

☐ F42.8 Other Obsessive Compulsive Disorder

☐ F42.9 Obsessive Compulsive Disorder Unspecified

☐ Other: _____

*Additional Medical Questions:

QUESTION:	ANSWER:
*How often will the patient see the psychiatrist?	
*Baseline YBOCS score	
*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 TMS therapy for depression? If so, Beginning date and rating scale score: Ending date and rating scale score:	☐ Yes ☐ No Date: _____ Rating scale: _____ Score: _____ Date: _____ Rating scale: _____ Score: _____
*Is the patient pregnant or nursing?	☐ Yes ☐ No
*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 had Cognitive Behavioral Therapy (CBT) for OCD/ERP? 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.	Provider: _____ Start Date: _____ Stop Date: _____ Current Frequency: _____ Total Number of Sessions: _____