TMS/ECT Authorization
(Transcranial Magnetic Stimulation/Electroconvulsive Therapy)

Today's date: _____

Patient name: _____ Phone: _____

ID number: _____ Date of birth: _____

Member address: _____

_____

Provider name/title: _____

Tax ID: _____ NPI: _____

Phone: _____ Fax: _____

Contact name: _____ Contact phone: _____

Diagnosis/ICD codes: _____

_____

List all proposed CPT/HCPCS codes (including units): _____

_____

Expected start date: _____

The clinical information below is mandatory to evaluate medical necessity and should be submitted along with this form to GEHA:

- ☐ Patient history/evaluation (including tried and failed treatments).
- ☐ Current presentation of symptoms.
- ☐ Treatment plan (including frequency and total number of sessions requested).

Please fax completed form and supporting documents to GEHA's Care Management Department at 816.257.3255 or 816.257.3515*.

Or mail documents to:

GEHA
Care Management Department
P.O. Box 21542
Eagan, MN 55121

***If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.**

Questions: Call Care Management at 800.821.6136, ext 3100.
Payable benefits are subject to the terms and conditions of the Health Benefit Plan.