TMS Prior Authorization Request

****Chart Notes Required****

Please fax to Behavioral Health: 503-574-8110 | Questions please call: 503-574-6400

NOTE: This form may only be used to request TMS.

Member Information		
Last Name:	First Name: Phone:	
Insurance ID #:	DOB:	
Address:	Date of Service:	Date Span Requested:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Servicing Facility:		TIN#:
Address:		NPI#:

ICD-10 Code(s):	CPT Code(s) & Number of Units Requested:
	☐ 90867 _____ ☐ _____
	☐ 90868 _____ ☐ _____
	☐ 90869 _____ ☐ _____

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.** ☐ New Patient ☐ Established Patient | Date last seen _____

Explanation Required:

****REQUIRED** Utilization Review Contact Information**:

Name:	Phone #:	Fax#:

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