

# Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)



Patient's Name: \_\_\_\_\_

Patient's Phone #: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Phone #: \_\_\_\_\_

### Indications For Use (Please check appropriate box):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Retard Disuse Atrophy   | <input type="checkbox"/> Re-Educate Muscle  | <input type="checkbox"/> Pain Control    |
| <input type="checkbox"/> Local Blood Circulation | <input type="checkbox"/> Relax Muscle Spasm | <input type="checkbox"/> Range Of Motion |
| <input type="checkbox"/> Other: _____            |   |  |

Primary Diagnosis: ICD-9 Code: \_\_\_\_\_

Secondary Diagnosis: ICD-9 Code: \_\_\_\_\_

Date of Injury/Onset: \_\_\_\_\_

### Previous Treatment(s)/Medication(s):

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> Prior Surgery    | <input type="checkbox"/> NSAIDS     | <input type="checkbox"/> Pain Medications |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Injections | <input type="checkbox"/> Other: _____     |

Length of Need:     Purchase (Lifetime)    6-10 Months (Long Term Need) \_\_\_\_\_ # of Months

Physician's Name (Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Signature Date: \_\_\_\_\_

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge.

**Please make sure the above information is substantiated in your patient's medical record.**

**DO NOT SUBSTITUTE**

**FAX FORM TO: 480.452.1518**