

Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)



Patient's Name: _____

Patient's Phone #: _____

Clinic Name: _____ Clinic Phone #: _____

Indications for use: Pain Control

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