Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)

Patient's Name*: _____ Patient's Phone*: _____

Patient's Address:_____

Clinic Name:_____ Clinic Phone: _____

Indications For Use: Pain Control

Primary ICD-10 Code*: _____

Secondary ICD-10 Code: _____

Date of Injury/Onset:_____

Previous Treatment(s)/Medication(s):

- ☐ Prior Surgery
- ☐ Physical Therapy
- ☐ NSAIDs
- ☐ Injections
- ☐ Pain Medications
- ☐ Other: _____

Length of Need: ☐ Purchase (Lifetime) ☐ 6-10 Months (Long Term Need) _____ # of Months

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge.
DO NOT SUBSTITUTE

Physician's Name (Print)*:_____ Phone*:_____

Physician's Signature*: _____ Signature Date*:_____

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

FAX FORM TO: 480.452.1518

***Required**