electromedical TECHNOLOGIES

Physician's Statement of Medical Necessity

Prescription for the WellnessPro 2010 Plus

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

Patient's Address:_____

Patient's Email 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*:**_____

Submit this RX along with any/all records to substantiate your claim to the Patients Health Insurance for DME preauthorization. If the patient would like to buy the Wellness Pro Plus and submit for reimbursement, fax this form to 480.452.1518

Referral ISR: _____

***Required**