PHYSICIAN'S WRITTEN ORDER

PATIENT INFORMATION: (Provide all information)

First Name _____ MI _____ Last Name _____ Date of Birth _____

PREVIOUS TREATMENT(S): (Check all that apply)

☐ Surgery ☐ Physical Therapy ☐ Medications ☐ Other: _____

MUST CHECK ONE BOX IN EACH SECTION (1 THRU 7) TO PRESCRIBE FOR DISUSE ATROPHY

PRODUCTS PRESCRIBED (check one in each section)

1. **Kneehab® XP Controller:** (NMES Controller – E0745)
   ☐ 1 Controller **OR** ☐ 2 Controllers

2. **Kneehab XP Conductive Garment:** (E0731)
   ☐ Left Garment **OR** ☐ Right Garment **OR** ☐ 2 Garments (Left & Right)

3. **Kneehab Supply Kit:** (4 conductive gel pads per kit – A4595) 2 Kits per Month
   ☐ 4 conductive gel pads per kit - Garment **OR** ☐ 4 electrodes per kit - Lead wires

DIAGNOSIS CODES (complete both primary and secondary code sections)

4. **Primary ICD-10 Code(s):** (check appropriate box or boxes)
   ☐ M62.50 Muscle atrophy, unspecified site
   ☐ M62.551 Muscle atrophy, right thigh
   ☐ M62.552 Muscle atrophy, left thigh
   ☐ M62.559 Muscle atrophy, unspecified thigh
   ☐ M62.58 Muscle atrophy, other site
   ☐ M62.59 Muscle atrophy, multiple sites
   ☐ Other (provide specific code) _____

5. **Secondary ICD-10 Code(s):** (reference coding guide on backside – including 7th Digit Extension for S Codes)
   List Code(s): _____ _____ _____ _____

LENGTH OF NEED

6. **Prescribed Length of Need:** (check one)
   ☐ 99 - Lifetime **OR** ☐ # of months _____

JUSTIFICATION FOR CONDUCTIVE GARMENT

7. **Justification:** (check one)
   ☐ Patient cannot manage without a conductive garment because of the large surface area that has many sites to be stimulated and the stimulation will be delivered so frequently that the use of conventional electrodes is not feasible.
   OR ☐ Other _____

I certify that I am the physician identified on this form and that I conducted the exam within 6 months of the date on this form. The above prescribed equipment is medically indicated and, in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition and is not prescribed as "convenience" equipment. I certify that the Patient/Caregiver has successfully completed, or will be trained on, the proper use of products prescribed on this Written Order. The physician notes, product lists and other supporting documentation will be provided to the Supplier or its Authorized Distributor upon request. I ask that there be no equipment substitutions for the devices prescribed.

_____ Physician's Signature **(Required)**

_____ Date of Signature **(Required; date stamps not acceptable)**

_____ Physician's Printed Name **(Required)**

_____ NPI# ( ) – Phone

Please make sure the above information is documented in your patient's chart notes – reference back of form.

Please fax signed form to the Distributor/IR Fax Number here: _____

From: _____

Or, fax signed form to **888-980-1195**