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: _____

DIAGNOSIS CODES *Note: Medicare does not accept non-specific diagnosis codes*

1. Primary ICD-10 Code(s): (check appropriate box or boxes)

Muscle wasting and atrophy, not elsewhere classified:

Shoulder:	☐ Right M62.511	☐ Left M62.512
Upper Arm:	☐ Right M62.521	☐ Left M62.522
Forearm:	☐ Right M62.531	☐ Left M62.532
Hand:	☐ Right M62.541	☐ Left M62.542
Lower Leg:	☐ Right M62.561	☐ Left M62.562
Ankle & Foot:	☐ Right M62.571	☐ Left M62.572
Thigh:	☐ Right M62.551	☐ Left M62.552

Not elsewhere classified: ☐ Other Site M62.58 ☐ Multiple Sites M62.59

Radiculopathy

Lumbar:	☐ M54.16
Cervical:	☐ M54.12
Thoracic:	☐ M54.14
Sacral & Sacrococcygeal:	☐ M54.18

Other: _____

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

List Code(s): _____ _____ _____ _____

PRODUCTS PRESCRIBED

3. Neurotech® Plus Controller: (NMES Controller – E0745)

☐ 1 Controller

4. Recovery Back Conductive Garment: (NMES Conductive Garment - E0731)

☐ 1 Garment

5. Supply Kit: (4 electrodes / conductive gel pads per kit – A4595)

☐ 4 conductive gel pads per kit - 2 Kits per Month

JUSTIFICATION FOR CONDUCTIVE GARMENT

6. 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: _____

LENGTH OF NEED

7. Prescribed Length of Need: (check one)

☐ 99 - Lifetime ☐ No. Months _____

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.

Please fax signed form to: Distributor/IR Fax Number here: ( ) –

Or, fax signed form to Neurotech: (888) 980–1195 or email: patientcare@neurotech.us