PRESCRIPTION & MEDICAL NECESSITY

PATIENT NAME* **DOB***

PHONE* **MOBILE/ALTERNATE**

NAME OF **WORK COMP** CARRIER*

LENGTH OF NEED:* ☐ LIFE-TIME ☐ 3-10 MONTHS ***(if blank, default is life-time)***

DX:* ICD-10: ______.____ ICD-10:______.____

PRESCRIBED DEVICE:

☑ Zynex NexWave Electrical Stimulator, Monthly Electrodes & Supplies

PRESCRIBED GARMENT:

☐ CONDUCTIVE LUMBAR SUPPORT (TSKIN) >>>> **WAIST** MEASUREMENT: _____ INCHES

☐ CERVICAL NECK WRAP (TSKIN) >>>> **NECK** MEASUREMENT: _____ INCHES

☐ CONDUCTIVE SHOULDER WRAP (TSKIN) >>>> **CHEST** MEASUREMENT: _____ INCHES

PROVIDER SIGNATURE* **DATE***

PRINTED NAME* **NPI***

ADDRESS

CITY ST ZIP CODE

PHONE FAX

I CERTIFY THAT THE EQUIPMENT AND SUPPLIES I PRESCRIBED ARE MEDICALLY NECESSARY FOR THIS PATIENT'S WELL-BEING; THIS IS NOT PRESCRIBED AS CONVENIENCE EQUIPMENT. IN MY PROFESSIONAL OPINION, THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT FOR THIS PATIENT'S CONDITION. SUBSTITUTION FOR THIS DEVICE IS *NOT ALLOWED WITHOUT MY WRITTEN APPROVAL.*

PLEASE FAX TO: (912) 450-1418 **STEWART, BRIAN**

PLEASE FAX WITH PATIENT DEMOGRAPHICS