ACTIVESTIM24

DME Rx Certificate of Medical Necessity

Patient: _____ DOB: _____

Ins. Co.: _____ Policy/Claim #: _____

Work Comp Adjuster: _____ Adjuster Phone: _____ DOI: _____

ICD-10 Codes: _____ ☐ No Substitutions

Length of Use: ☐ ____ mo.(s) ☐ Purchase

Prescribed Electrotherapy Products:

☐ Muscle Stim - E0745 ☐ Interferential - E1399 ☐ Low Back Conductive Garment - E0731

☐ MicroCurrent - E1399 ☐ Full Back Conductive Garment - E0731

☐ Electrodes: ☐ 6 months ☐ 12 months ☐ Other: _____

Indications Related to Electrotherapy Products:

☐ Relieve acute pain ☐ Prevent or retard disuse atrophy ☐ Re-educate muscle

☐ Relax muscle spasms ☐ Relieve and manage chronic pain ☐ Reduce Edema

☐ Increase local blood circulation

☐ Patient requires a conductive garment to treat the area of pain because the area is inaccessible with conventional electrodes.

Please Send Order To:

Coyote Stone, LLC | 10818 NE Coxley Dr. Suite L, Vancouver, WA 98662
Email: billing@coyotestone.com | Phone: 888.211.6036 | Fax: 360.395.6700

Physician Signature: _____

Date: _____ NPI: _____

Physician Name (Please Print): _____

Phone: _____

This is written confirmation of verbal orders given by me prior to use of the equipment/procedure. I certify that the above prescribed equipment is medically necessary in reference to accepted standards of medical practice in treatment of this patient condition and not prescribed as "convenience" equipment.

COYOTE STONE LLC