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PRESCRIPTION FOR PELVIC FLOOR ELECTRICAL STIMULATOR (E0740)

Patient's Name _____

Patient's Address _____

Patient's Phone _____

The patient has undergone and failed in a documented trial of
pelvic muscle exercise training to include: _____
prescribed for a duration of 4 weeks YES___NO____

Are the results documented in the patient's medical notes? YES___NO____
Is the patient cognitively intact? YES___NO____

ICD-10 Diagnosis Code(s): _____

CERTIFICATE OF MEDICAL NECESSITY

The above identified equipment is deemed medically necessary for an estimated period of time below:

- ✓ Life time use
- ✓ No substitutions

Physician's Name _____

Address _____

Phone _____ Fax _____

NPI _____

Physician's Signature Date