

Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)



Patient's Name*: _____ Patient's Phone*: _____

Patient's Address: _____

Clinic Name: _____ Clinic Phone: _____

Indications For Use: Pain Control

Primary ICD-10 Code*: _____

Secondary ICD-10 Code: _____

Date of Injury/Onset: _____

Previous Treatment(s)/Medication(s):

- Prior Surgery
- NSAIDs
- Pain Medications
- Physical Therapy
- Injections
- Other: _____

Length of Need: Purchase (Lifetime) 6-10 Months (Long Term Need) _____ # of Months

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge.
DO NOT SUBSTITUTE

Physician's Name (Print)*: _____ Phone*: _____

Physician's Signature*: _____ Signature Date*: _____

Please make sure the above information is substantiated in your patient's medical record.

FAX FORM TO: 480.452.1518

*Required