electromedical technologies

GWP 1246

Physician's Statement of Medical Necessity

Prescription for Transcutaneous Electro Nerve Stimulator

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

Patient's Address:_____

Patient's Email 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**