Attention: Jack White, Alpha-Stim Clinical Sales and Support for North Carolina
Fax Order to 888-979-6320

Statement of Medical Necessity Form for Alpha-Stim

Date ________________________

PATIENT INFORMATION

Name______________________________ Date of Birth ______________

Address______________________________ Home Phone ______________

City______________ State__________ Zip__________ Cell Phone ______________

Email ____

To Whom It May Concern:

I am ordering the purchase of an Alpha-Stim® prescription electromedical device complete with accessories for the above named patient to use at home as a conservative method of treating pain, anxiety, depression and/or insomnia. This technology is supported by successful outcomes documented by more than 80 published articles (see **Alpha-Stim Research** for annotated abstracts). It has shown to be consistently effective so I have advised the patient to utilize it on a regular basis.

I want this patient to have the following Alpha-Stim® device:

☐ **Alpha-Stim® M** microcurrent stimulator for the treatment of pain, anxiety, depression, and/or insomnia

☐ **Alpha-Stim® AID** cranial electrotherapy stimulator for the treatment of anxiety, depression, and/or insomnia.

The patient's current diagnoses applicable to the Alpha-Stim® treatments are:

1. ______________________________ ICD10 Code: ______________
2. ______________________________ ICD10 Code: ______________
3. ______________________________ ICD10 Code: ______________
4. ______________________________ ICD10 Code: ______________

Yours truly,

LICENSED HEALTHCARE PRACTITIONER INFORMATION

Name, Degree ______________________________

NPI______________________ State License/UPIN______________________

Address______________________________ Phone______________________

______________________________ Fax ______________________

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City______________ State__________ Zip __________

Signature ______________________________