**Certificate of Medical Necessity of NMES**



**SECTION A**: **Certification Date of Initial Rental Period:** \_\_\_/\_\_\_\_\_/\_\_\_\_\_ **SECTION B**: **Patient Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph.: \_\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Order Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_

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| **SECTION C: Information MUST fill by the Ordering Physician**  |
| EST. LENGTH OF NEED: (# OF MONTHS): \_\_\_\_ 1-99(*99=LIFETIME*) DIAGNOSIS CODE(s) \_\_\_\_\_\_\_\_,\_\_\_\_\_\_ Place of Service: \_\_\_\_\_\_\_\_\_\_\_ Service Procedure: \_\_\_\_\_\_\_\_\_ |

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| **ANSWERS**  | ANSWER QUESTIONS 1-6 FOR purchase of **NMES** (Circle Y for Yes, N for No,)  |
| **Y / N**  | 1.) Does the patient have muscle weakness/muscle atrophy?  |
| **\_\_\_\_\_\_Months**  | 2.) How long has the patient had muscle weakness? Enter number of months, (1-99.)  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | 3.) What **NMES** unit being prescribed for?  |
|  **Y / N**  | 4.) Is there documentation in the medical record for multiple medications and/ or other therapies that have been tried and failed?  |
| **Y / N**  | 5.) Has the patient received NMES trial of at least 30 days?  |
| **\_\_\_/\_\_\_\_/\_\_\_\_\_**  | 6.) What is the date that you reevaluated the patient at the end of the trial period?  |

NAME OF THE PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please print): NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TITTLE: \_\_\_\_\_\_\_\_\_\_\_ EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION D: Description and Cost: INTENSITY TWIN STIM #D13717 Purchase Cost: $ 1,031.00

### SERIAL Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purchase Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

*I certify that I am the physician identified in* ***Section E*** *of this form. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge.*

## SECTION E: Provider Information

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date signed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Address/City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_