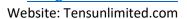


5145 N. Academy Blvd. Suite#210 Colorado Springs, CO 80918 Phone: (719) 638-4056

Fax: (719) 638-4080 Email: tens@tensunlimited.com





## **DMF Written Order Form**

DME Written Order Form			FAX TO: (719) 638-4080		
PATIENT INFORMATION					
Patient:	DC	B:/	Order Da	ate:/	
Address:	City:		State:	Zip:	
Ph:	Email Address:				
Primary Ins. & ID#	Secondary Ins. & ID#				
Check all that apply:					
KNEE BRACING:	ANKLE/ SUPPORTS:	BACK:	TH	HERAPIES:	
Hinged knee brace	Crutches	Back brac	:e LSO*	TENS Unit	
OA knee brace	Pneumatic walking boot	Back brace	:e LO	NMES Unit	
	Knee Walker			Bone Growth Stim	
	Knee Scooter			Cervical air traction	
Lead wire	Electrodes	Battery		Conductive spray	
Conductive Carment/s	s): Certificate of Medical Neces	city - Datient cann	ot manage w/	o the conductive	
-	nronic intractable pain because	<u>-</u>	•		
_	ctrodes, adhesive tapes and lea		to be stimula	te are maccessible with	
	to 300 lbs Power Wheeld		Pow	ver Wheelchair 401 to 600 lbs	
Electric Scooter	Heavy Electric	Scooter 400 lbs		avy Duty Scooter 600lbs	
		Non- Ambulatory			
Any resupply for TENS Unit order,	MUST provide the following information	on for insurance covera	age.		
Serial Number:	Date of Purcha	ise://_	Model:		
Date:/,,,					
				· <del></del>	
Length of need: Seven	ity of pain Dura	LION OF PAIN	_ Etiology of p	dIII	
Prior treatment(s)			·		
medical necessity information physician notes and other suther patient is aware that DN	ian identified in this form. I have on in is true, accurate and compupporting documentation will be ME may contact them for any act of the patient's medical recor	plete to the best o e provided to DM Iditional informati	f my knowledg E upon reques	ge. The product lists and st. I acknowledging that	
REQUESTING PHYSICIAN IN	PURIVIATION				
Physician Name:		NPI:			

Signature: \_\_\_\_\_\_ Date Signed: \_\_\_\_\_/\_\_\_\_ Address: \_\_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_\_ Fax: \_\_\_\_\_