T.E.N.S. UNLIMITED INC.

5145 N. Academy Blvd. Suite#210
Colorado Springs, CO 80918
Phone: (808) 722-0226
Fax: (808) 200-0391
Email: hawaii@tensunlimited.com
Website: Tensunlimited.com

DME Written Order Form

FAX TO: (808) 200-0391

PATIENT INFORMATION

Patient: _____DOB: ___/____/_____ Order Date: ____/____/_____

Address: _____City: _____ State: _____Zip: _____

Ph: _____-_____-_____ Email Address: _____

Primary Ins. & ID#_____ Secondary Ins. & ID#_____

Check all that apply:

KNEE BRACING:
- ☐ Hinged knee brace
- ☐ OA knee brace

ANKLE/ SUPPORTS:
- ☐ Crutches
- ☐ Pneumatic walking boot
- ☐ Knee Walker
- ☐ Knee Scooter

BACK:
- ☐ Back brace LSO*
- ☐ Back brace LO

THERAPIES:
- ☐ TENS Unit
- ☐ NMES Unit
- ☐ Bone Growth Stim
- ☐ Cervical air traction

☐ Lead wire ☐ Electrodes ☐ Battery ☐ Conductive spray

☐ **Conductive Garment(s): Certificate of Medical Necessity-** Patient cannot manage w/o the conductive garment for treatment of chronic intractable pain because the areas or sites to be stimulate are inaccessible with the use of conventional electrodes, adhesive tapes and lead wires

_____ Power Wheelchair up to 300 lbs ____ Power Wheelchair 301 to 400 lbs ____ Power Wheelchair 401 to 600 lbs
_____ Electric Scooter ____ Heavy Electric Scooter 400 lbs ____ Heavy Duty Scooter 600lbs
_____ Weight _____ Height ____ Percentage of Non- Ambulatory

Any resupply for TENS Unit order, MUST provide the following information for insurance coverage.

Serial Number: _____ Date of Purchase: ____/_____/_____ Model: _____

Date: ___/___/_____ Face to face Encounter: ICD 10 Code: _____, _____, _____

Length of need: ____ Severity of pain _____ Duration of Pain_____ Etiology of pain _____

Prior treatment(s)_____.

I certify that I am the physician identified in this form. I have revied the detailed Written Order. I certify that the medical necessity information in is true, accurate and complete to the best of my knowledge. The product lists and physician notes and other supporting documentation will be provided to DME upon request. I acknowledging that the patient is aware that DME may contact them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

REQUESTING PHYSICIAN INFORMATION

Physician Name: _____NPI: _____

Signature: _____ Date Signed: _____/____/_____

Address: _____City: _____ State/Zip: _____

Phone: _____ Fax: _____