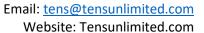


5145 N. Academy Blvd. Suite#210 Colorado Springs, CO 80918 Phone: (719) 638-4630

Fax: (719) 638-4080





DIVIE Written Order Form		FAX I	O: (719) 638-4080
PATIENT INFORMATION			
Patient:	DOB:/_	/ Orde	er Date:/
Address:	City:	State:	Zip:
Ph: Email <i>F</i>	\ddress:		
Primary Ins. & ID# Secondary Ins. & ID#			
Check all that apply:			
KNEE BRACING: Hinged knee brace OA knee brace  OA knee brace Knee Walk Knee Scoot	walking boot er	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  ADDITIONAL PRODUCTS:			
Any resupply order, <b>MUST</b> 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 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			
magazoniro i motomir ini ottaminora			
Physician Name:	NF	રાઃ	
Signature:			

Address: \_\_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

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