T.E.N.S.
UNLIMITED LLC
DURABLE-MEDICAL EQUIPMENT

Rx

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DURABLE MEDICAL EQUIPMENT
PAIN MANAGEMENT EQUIPMENT DWO

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: ___/___/_____ ORDER DATE: ___/___/_____

PHONE: ____-____-_____ ADDRESS: _____ CITY: _____ STATE/ZIP: _____

*********PLEASE PROVIDE DEMOGRAPHIC AND OFFICE NOTES FOR PROCESSING**********

Requesting Durable Medical Equipment

Bracing	Therapies	Mobility
○ OA Knee Brace L1852 ○ Pneumatic Knee Brace L1848 ○ Pneumatic Walking Boot L4361 TALL ____ Short_____ ○ Back Brace L0648 ○ Back Brace L0650 ○ Cervical Traction E0849 ○ Ankle Brace L1902 ○ Wrist Brace L3908	○ TENS Unit E0730 ○ EMS Unit E0745 ○ Electro therapy supplies Electrodes, Lead wires, batteries ○ Bone Growth Stimulator E0747 ○ UVB Light Therapy Wand E0691 ○ Conductive Garments E0731 & CG Spray A4558 Treatment areas_____	○ Forearm Crutches E0111 ○ 2 Wheel Walker E0143 ○ Wheelchair Standard K0001 ○ Wheelchair Heavy Duty K0006

***Patient Diagnosis: _____ _____ _____ _____

REQUESTING PHYSICIAN INFORMATION

Physicians Name: _____ NPI: _____

Signature: _____ Signed Date: _____/_____/_____

Contact Phone: _____-_____-_____ Contact Fax: _____-_____-_____

Address: _____ City: _____ State/Zip: _____

I certify that I am the physician identified in this form. I have reviewed the detailed written order. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I will provide medical documentation and sign additional documents required by the patient's insurance to help with the DME processing. I acknowledge that the patient is aware that the DME provider may contact them for any additional information to process this order. A copy of this order will be retained as a part of the patient's medical record.