Equiscope Sessions (Microcurrent Therapy) for Symptom Treatment

Patient Name: _____ DOB: _____
Treating Equiscope Practitioner: _____
Date: _____

What the patient is requesting

The patient is requesting that you consider supporting **Equiscope (microcurrent therapy) sessions** as part of a symptom-focused treatment plan. These sessions are intended to support care for symptoms such as **pain, inflammation, neuromuscular dysfunction, injury recovery, and physiologic dysregulation**.

What the Equiscope session is

Equiscope sessions use **therapeutic microcurrent** applied externally. The purpose is to support **pain management, tissue recovery support, reduction of inflammation, and neuromuscular communication** as clinically appropriate for the patient's symptoms.

How to decide medical necessity

If, in your clinical judgment, this service supports treatment for the patient's condition or symptoms, you may document medical necessity in a Letter of Medical Necessity (LMN) by tying the recommendation to:

- A specific diagnosis or symptom set
- Functional impact (mobility, sleep disruption, activity limitation, headaches, recovery limitations)
- A defined treatment period and frequency

What to include in the LMN (recommended language)

Please include the following elements:

1. **Condition or symptom set being treated** (ICD-10 optional)
2. **Medical rationale** for using microcurrent therapy as part of the care plan
3. **Frequency and duration** (example: 1–2 sessions/week for 8–12 weeks)

4. Statement that the service is intended to **treat/mitigate symptoms** and/or **affect a structure or function of the body**

Copy and Paste LMN:

I am the treating clinician for this patient. Based on my evaluation, I recommend microcurrent therapy (Equiscope sessions) as part of the treatment plan to mitigate symptoms including _____. This therapy is intended to support medical care by treating symptoms and affecting a structure or function of the body. Recommended frequency is ____ per week/month for ____ weeks/months (from ____ to ____)."

Notes for the plan administrator (optional)

The patient may submit your LMN along with itemized receipts to their HSA/FSA administrator. Eligibility is determined by the patient's plan rules.

Clinician Signature: _____ **Date:** _____
Printed Name: _____
License #: _____ **NPI (optional):** _____