Medical Necessity Form

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____

Insurance No.: _____ Group No.: _____

Policy Holder Name: _____

Medical Necessity Information

Diagnosis & ICD9 CM Codes:

- ☐ 596.59 Detrusor Instability
- ☐ 625.6 Stress Incontinence, female
- ☐ 788.31 Urge Incontinence
- ☐ 788.32 Stress Incontinence, male
- ☐ 788.33 Mixed Incontinence
- ☐ 788.39 Other Incontinence
- ☐ 787.6 Fecal Incontinence
- ☐ 728.87 Muscle Weakness
- ☐ 728.85 Muscle Spasm
- ☐ Other _____
- ☐ Other _____

InTone is prescribed to: (check all that apply)

- ☐ Improve urethral closure function
- ☐ Improve urethral sphincter function
- ☐ Inhibit unwanted bladder contractions
- ☐ Other _____
- ☐ Other _____

Are the pelvic nerves intact? ☐ Yes ☐ No

How many incontinent episodes? ▼

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Anticipated benefit from use: (check all that apply)

- ☐ Increased pelvic muscle strength
- ☐ Decreased urinary leakage
- ☐ Decreased involuntary detrusor contractions
- ☐ Other _____
- ☐ Other _____

Has patient undergone and failed a 4 week documented trial of Pelvic Muscle Exercise (PME) training? ☐ Yes ☐ No

Is patient cognitively intact? ☐ Yes ☐ No

I am prescribing the InTone System HCPCS Code E0740 NU.

Prescribing Physician Name: _____ UPIN# _____

Address: _____ NPI# _____

_____ Phone#: _____

Date: _____

_____

Physician Signature

I, the above signed, confirm the order for the above named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of the patient's condition.

The information is requested to document medical necessity for the use and purchase of InTone™ products. This form must be completed and signed by the patient's attending physician to be valid. If ordering from our website, www.incontrolmedical.com, please fax to 262-373-0463.