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Statement of Medical Necessity (Prescription)

Patient's Name: _____Date of Birth: _____
Patient's Address: _____
Patient's Phone #: _____
Date of Injury/Onset: _____ Date of Last Office Visit: _____

Diagnosis / ICD9:

___ 338.4 Chronic Pain
___ 338.28 Pain: Postoperative: Chronic
___ 729.5 Pain: Extremity (lower)(upper)
___ 724.5 Pain: Back (postural)
___ 724.2 Pain: Back: Low
___ 719.40 Pain: Joint
___ 729.5 Pain: Joint: Ankle
___ 719.42 Pain: Joint: Elbow
___ 719.47 Pain: Joint: Foot
___ 719.44 Pain: Joint: Hand
___ 719.45 Pain: Joint: Hip
___ 719.46 Pain: Joint: Knee
___ 719.49 Pain: Joint: Multiple Sites
___ 719.45 Pain: Joint: Pelvic Region
___ 719.41 Pain: Joint: shoulder (region)
___ 719.43 Pain: Joint: wrist
___784.0 Pain: face, facial
___350.2 Pain: face, facial: Atypical
___351.8 Pain: face, facial: Nerve
___729.5 Pain: Finger
___729.5 Pain: Foot
___729.5 Pain: Hand

Other ICD -9 Codes:

Other Diagnosis:_____
Previous Treatment(s)/Medications (include dosage if medication):_____
_____
Results: Check the one that applies:

_____ Previous treatments were sufficiently effective.
_____ Previous treatments failed and were not sufficiently effective.

Product Description:

Transcutaneous electro stimulator TENS device: CHANS-0 1-SCENAR-(M) ™ device with lead wire and conductive pads
Conductive Garment ___ is ____ is not medical necessity.
Check any that apply:

___ Large area to be treated
___ Multiple sites to be treated
___ Areas are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
___ Medical conditions, such as skin problems, that precludes the application of conventional electrodes
___ Therapy required beneath a cast

Left	Carpal wrap	Elbow wrap	Conductive glove
Right	Ankle wrap	Shoulder wrap	Conductive sleeve
Both	low back wrap (6 inches tall)	Arm or leg wrap	Conductive sock
	low back wrap (8 inches tall)	Cervical wrap	Conductive leg sleeve

Length of Need : _____# of Months (short term) _____9 months or longer (long term) _____Purchase
I certify that the above prescribed treatment is medically necessary for the patient's well being. In my opinion, the treatment is effective and is reasonable in the treatment of this patient's condition.
I also certify that the ELECTRODE GARMENT information noted above is accurate to the best of my knowledge.
Physician's Signature:_____ Date:_____
Physician's Name (print):_____ NPI number:_____
Clinic Name: _____ Phone#: _____
Physician's Address:_____