

Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)



Patient's Name: _____

Patient's Phone #: _____

Clinic Name: _____ Clinic Phone #: _____

Indications For Use (Please check appropriate box):

- Retard Disuse Atrophy Re-Educate Muscle Pain Control
 Local Blood Circulation Relax Muscle Spasm Range Of Motion Other: _____

Primary Diagnosis: ICD-9 Code: _____

Secondary Diagnosis: ICD-9 Code: _____

Date of Injury/Onset: _____

Previous Treatment(s)/Medication(s):

- Prior Surgery NSAIDS Pain Medications
 Physical Therapy Injections Other: _____

Length of Need: Purchase (Lifetime) 6-10 Months (Long Term Need) _____ # of Months

Physician's Name (Print): _____ Phone: _____

Physician's Signature: _____ Signature Date: _____

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge.

Please make sure the above information is substantiated in your patient's medical record.

DO NOT SUBSTITUTE

FAX FORM TO: 480.452.1518

Sacred Enterprises LLC trn1234