Physician's Statement of Medical Necessity (Prescription)

(Transcutaneous Electro Nerve Stimulator)

Sacred Enterprises LLC

Wellness Pro®

Patient's Name: ____

Patient's Phone #:______________________________

Clinic Name:__________________________________ **Clinic Phone #:**____________________

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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

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