PRESCRIPTION AND LETTER OF MEDICAL NECESSITY

PATIENT NAME: _____ D.O.B. _____ D.O.I. _____

PERIOD OF MEDICAL NECESSITY (NO OF MOS): _____ 1-99 (99=LIFETIME)

(CIRCLE ONE): PURCHASE RENTAL	PRESCRIBED USAGE: x DAILY	x PER WEEK

ELECTROTHERAPY

	TENS UNIT & SUPPLIES	SERIAL NUMBER:
	GLOVE GARMENT	
	KNEE GARMENT	
	SOCK GARMENT	
	SHOULDER GARMENT	
	SLEEVE GARMENT	
	WRIST GARMENT	

ORTHOTICS

	LUMBOSACRAL SUPPORT	SIZE:
	ANKLE LACE-UP	SIZE:
	ANKLE AIR STABILIZER	SHOE SIZE:
	KNEE BRACE	SIZE:
	WRIST BRACE	(CIRCLE ONE) R L
	WRIST/THUMB BRACE	R L

OTHER

	CERVICAL POSTURE PUMP			
	SPINAL Q VEST	CHEST SIZE	WEIGHT	HEIGHT

ICD-10 CODES

CHIEF COMPLAINT

S.O.A.P. NOTES

SUBJECTIVE:

OBJECTIVE:

ASSESSMENT:

PLAN:

PREVIOUS TREATMENT

☐ ACUPUNCTURE	☐ ELECTROTHERAPY	☐ HEAT/ICE THERAPY
☐ MANIPULATION	☐ MASSAGE THERAPY	☐ PHYSICAL THERAPY

MEDICATIONS PERTAINING TO PAIN MANAGEMENT

LETTER OF MEDICAL NECESSITY

I have implemented a trial use of TENS in my office which has proven beneficial in alleviating the patient's pain. Their pain level has gone from _____ to _____ (pain level 1-10, 10 being the highest of pain) Therefore, I am recommending the patient to continue the use of a TENS unit at home for the period time prescribed above. I have reviewed the warnings, precautions and explained the use of the TENS unit with the patient.

DR. SIGNATURE: _____ DATE: _____ NPI: _____

PRINTED NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____