



Electrotherapy Prescription/Assignment of Benefits/Letter of Medical Necessity

FAX TO: _____

Please provide the information requested below and complete the form in full.

Clinic Information

Clinic Name _____ Acct# _____ Phone _____ Fax _____
 Clinic Address _____ City _____ State _____ Zip _____ Contact _____
 Sales Representative _____ Territory # _____ Phone _____

Dispense Method Ship device to Clinic Ship Device to Patient's home address

Patient Assignment of Benefits/Release of Information

Private Medicare Workers Compensation Self Pay Medicaid Auto: Date of Injury _____
 Patient Name _____ Date of Birth _____ SS# _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Alt Phone _____
 Insurance _____ Policy/Claim # _____ Group # _____
 Insured's Name _____ Emergency Contact Name/Phone _____

By signing below, I authorize Empi to submit a claim for such product(s) to my insurer on my behalf and assign the benefits payable by my insurer to Empi. I authorize my Health care Provider and Empi to release any of my medical information required by my insurer to process the claim. I understand that Empi does not waive patient balances and that I am responsible for and agree to pay any portion of the amount due for such product(s) not paid for by my insurer, whether resulting from deductibles, co-pays, determination of non-coverage, or otherwise. I understand that the Patient Bill of Rights and Responsibilities, the CMS Medicare Supplier Standards and the Empi Notice of Privacy Practices are included in the device package and that I can contact customer service at 800-328-2536 if I have questions about the documents.

*Patient Signature _____ Date of Signature _____
*REQUIRED FOR HOME DELIVERY
 Guarantor/Legal Rep (if patient unable to sign): _____
 Relationship to Patient _____ Date _____

DEVICE REQUESTED: Empi Active™ TENS Back and Supplies Empi Active™ TENS Knee and Supplies EasyWear Garment
 Select™ TENS and Supplies 300PV® and Supplies IF3Wave® and Supplies Other _____

MEDICAL NECESSITY / LENGTH OF NEED

Purchase (99 = Lifetime) Rental # _____ months **ICD9 CODES** _____
 Primary ICD-9 Code _____ Secondary ICD-9 Code _____

Previous Treatment(s)/ Medications: Prior Surgery NSAIDS/ Pain Medications Physical Therapy Injections
 Other _____

Primary Indication For Use - Completion Required for 300 PV (Check One)

Retard disuse atrophy/muscle weakness Re-educate muscles Relax muscle spasms Pain control

TENS — Medicare/Medicaid Completion Required

Medicare requires that we maintain documentation supporting a patient's need for two-channel (4 lead) TENS device. In addition, the supplier must substantiate that the patient has chronic intractable pain and the duration of this pain.

Patient is using for (check one): Chronic Intractable Pain Acute Post Op

HOW MANY MONTHS HAS YOUR PATIENT HAD CHRONIC INTRACTABLE PAIN (99=LIFETIME): _____

Justification for 4 leads (2 channel) versus 2 leads (1 channel)

- Patient's pain covers a large area and 4 electrodes are needed to surround or treat throughout the pain area.
- 4 electrodes are needed to treat two different pain areas.
- Patient has a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along pain pattern.
- Other: _____

Empi EasyWear Garment – Medicare/Medicaid Completion Required

Patient has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes and leadwires. *If yes, please attach the patient's medical record as supporting documentation.* Yes No

Physician Name: _____ NPI#: _____ Phone: _____

*Physician Signature: _____ Date of Signature: _____

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. Please make sure the above information is substantiated in your patient's medical record.

*Signature stamps are not permitted for Medicare.

DO NOT SUBSTITUTE

Prescription