



# Physician's Statement of Medical Necessity (Prescription)

Please complete, sign, date and fax to (214) 575-2824

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_

Date of Injury/Onset: \_\_\_\_\_ Date of Face-to-Face Examination within past 6 months: \_\_\_\_\_

**Diagnosis / ICD-10** that the patient was evaluated and/or treated for:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> G89.29 Chronic Pain                    | <input type="checkbox"/> M25.561/M25.562 R / L Pain: Joint: Knee              | <input type="checkbox"/> M79.601/M79.602 R / L Pain: Arm     |
| <input type="checkbox"/> G89.28 Pain: Postoperative: Chronic    | <input type="checkbox"/> M25.571/M25.572 R / L Pain: Joint: Ankle             | <input type="checkbox"/> M79.641/M79.642 R / L Pain: Hand    |
| <input type="checkbox"/> M54.9 back pain                        | <input type="checkbox"/> M79.671/M79.672 R / L Pain: Joint: Foot              | <input type="checkbox"/> M79.644/M79.645 R / L Pain: Fingers |
| <input type="checkbox"/> M54.5 Lumbar region pain               | <input type="checkbox"/> M25.531/M25.532 R / L Pain: Joint: Wrist             | <input type="checkbox"/> R10.2 Pain: Joint: Pelvic Region    |
| <input type="checkbox"/> M25.551/M25.552 R / L Pain: Joint: Hip | <input type="checkbox"/> M25.521/M25.522 R / L Pain: Joint: Elbow             | <input type="checkbox"/> G50.1 Pain: Face: Facial, Atypical  |
| <input type="checkbox"/> M79.604/M79.605 R / L Pain: Joint: Leg | <input type="checkbox"/> M25.511/M25.512 R / L Pain: Joint: Shoulder (region) |  |

Other ICD-10 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:**

Microcurrent Avazzia Bio-Electric Stimulation Technology™ TENS BEST-PRO 1™ device with lead wire and conductive pads

**Length of Need:** \_\_\_\_\_ Number 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 wellbeing. In my opinion, the treatment is effective and is reasonable in the treatment of this patient's condition. I also certify that the information noted above is accurate to the best of my knowledge.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (print): \_\_\_\_\_ NPI number: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

**DO NOT SUBSTITUTE CONFIDENTIAL INFORMATION**