# PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY

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:

- __G89.29 Chronic Pain
- __G89.28 Pain: Postoperative: Chronic
- __M54.9 back pain
- __M54.5 Lumbar region pain
- __M25.551/M25.552 R / L Pain: Joint: Hip
- __M79.604/M79.605 R / L Pain: Joint: Leg
- __M25.561/M25.562 R / L Pain: Joint: Knee
- __M25.571/M25.572 R / L Pain: Joint: Ankle
- __M79.671/M79.672 R / L Pain: Joint: Foot
- __M25.531/M25.532 R / L Pain: Joint: Wrist
- __M25.521/M25.522 R / L Pain: Joint: Elbow
- __M25.511/M25.512 R / L Pain: Joint: Shoulder (region)
- __M79.601/M79.602 R / L Pain: Arm
- __M79.641/M79.642 R / L Pain: Hand
- __M79.644/M79.645 R / L Pain: Fingers
- __R10.2 Pain: Joint: Pelvic Region
- __G50.1 Pain: Face: Facial, Atypical

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 TENS device
- ○ TENS Accessories ___are/___are not a medical necessity.
  - ○ Y-Electrode
  - ○ Pencil Electrode
  - ○ Brush Electrode
  - ○ 2"x2" Self-Adhesive Conductive Gel pads

**Physician's Notes:**

Check all that apply

- ○ Areas are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
- ○ Medical conditions, such as skin problems, that preclude the application of conventional electrodes
- ○ Large area to be treated
- ○ Multiple sites to be treated

Length of Need:

- ___Number of months (short term)
- ___10 months or longer (long term)
- ___Purchase

I certify that the above prescribed treatment is medically necessary for the patient's well-being. In my opinion, the treatment is effective and 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: ____________________________________________________________________________

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