

Please Fax this prescription to:

Fax# (616) 772-9368



Prescription & Letter of Medical Necessity

X-CEL 4000

Transcutaneous Electrical Nerve Stimulator (T.E.N.S)
(Integrating TENS with Interferential and Neuromuscular Options)

DURATION: 2 - 12 Months Rental or Purchase if necessary

Supplies as needed

First Name _____ Last Name _____

Date of Birth ____/____/____ Insurance I.D. # _____

Clinic Name _____ Clinic Phone (____) ____-____

Date of Injury/Onset ____/____/____ Medicare # _____

Physician's Full Name: Dr. _____

Electrode Requirements

Medical Necessity for 4 leads (2 channels) versus 2 leads (1 channel)

- _____ 4 electrodes are needed to surround and treat a large pain area
- _____ 4 electrodes are needed to treat two different areas
- _____ 4 electrodes are needed to utilize a crossed, interfering stimulation pattern
- _____ Other (please explain) _____

Medical Necessity for a 4 Lead electro-mesh garment

- _____ Treatment site is inaccessible to place disposable electrodes
- _____ Additional support is needed
- _____ Skin sensitivity and or skin type
- _____ Garment is needed to surround a large treatment area
- _____ Other (please explain) _____

DIAGNOSIS:

Primary ICD.9 Code

Secondary ICD.9 Code

HISTORY:

Previous Treatment(s) / Medication(s)

- Prior surgery Injections NSAIDS
- Physical Therapy Pain Medication(s) Other: _____

MEDICAL NECESSITY:

Primary Indications for Use

- Retard disuse atrophy Relax muscle spasms Chronic pain control / management

X

Physician Signature (Required)

Date:

Phone # (____) ____-____ FAX # (____) ____-____ NPI # _____

I certify that the information noted above is accurate and complete to the best of my knowledge.

Do not substitute product or program



Advanced Therapy Concepts

(800) 864-0293 Toll Free