Prescription & Letter of Medical Necessity

Patient Name: (**REQUIRED**)	Date of Birth (**REQUIRED**):	Date of Incident:	Referring Clinic Name: (**REQUIRED**)

INSURANCE:
☐ Attorney ☐ Auto ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ Work Comp

☑ Zynex Ewave - NMES and Supplies

Supplies: 4 packs of re-usable electrical stimulation electrodes and 4 Zynex 9 volt batteries once per month as prescribed for length of need stated below. Medicare patients receive 2 packs or 8 electrodes and 4 Zynex 9 Volt Batteries.

Length of Need: ☐ 99 mos. (lifetime) ☐ 6-9 mos. ☐ 3-6 mos.

Frequency of Use: _____

Diagnoses/ICD-9: 1. _____ 2. _____ 3. _____

PHYSICIAN INFORMATION

I certify that the equipment and supplies I prescribed is Medically Necessary for this patient's well-being. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. It is NOT prescribed as convenience equipment.

Substitution for this device is *NOT ALLOWED* without my written approval.

PHYSICIAN'S SIGNATURE _____ **DATE** _____/_____/_____
(Stamped Signatures are not acceptable)

PRINTED PHYSICIAN'S NAME: _____ NPI#_____

ADD: _____(P) (_____) _____(F) (_____) _____

Required for ALL Medicare Patients

Chart Notes & Rx must be submitted together

Indications for use:

☐ Prevention or retardation of disuse atrophy **(Required for ALL)**
☐ Prevention or retardation of disuse atrophy
☐ Increasing local blood circulation
☐ Maintaining or increasing range of motion
☐ Relaxation of muscle spasms

Include chart notes supporting Medical Necessity (clinical documentation must support the continued need, use and benefit that the device provides).

Representative: Zynex Medical (P): 800-495-6670 (Fax): 866-791-2026