PATIENT INFORMATION

Patient Name	**D.O.B**
Phone	Mobile

PRESCRIBER'S INFORMATION

Physician Name			**NPI**
Address			Phone
City	State	Zip	Fax

PRESCRIBED PELVIC FLOOR STIMULATOR

Zynex InWave Pelvic Floor Stimulator & Probe for treatment of Urinary Incontinence

Please Indicate The Following:

LON: ☐ 3-10 Months

DX: ☐ **N39.41 Urge IC** ☐ **N39.3 Stress IC** ☐ **N39.46 Mixed IC**

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's urinary incontinence, this is NOT prescribed as convenience equipment. 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.

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

Provider Signature _____ **Date** _____

Please Fax To: 1-866-717-6120 For Immediate Processing

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