



Prescription & Letter / Certificate of Medical Necessity

**Zynex Medical
(P) 800-495-6670
(F) 800-495-6695**

Patient Name:	Date of Birth MM/DD/YY	SS #:
Patient Home Phone #:	Insurance	
Clinic Name & Phone #:	Date of Incident: MM/DD/YY ____/____/____	

ELECTROTHERAPY

Zynex - IF8100 - IFC and Supplies

Length of Need (required):

Purchase Long-term 6-9 mos 3-6 mos

Low Back Pain

Patient requires a **conductive garment** to treat the area of chronic intractable pain because the area is inaccessible with conventional electrodes.

LSO SPINAL ORTHOSIS

LSO - Lumbar Sacral Orthosis

Treatment for:

Post Surgical Lumbar Sacral Stabilization
 Chronic Back Pain

KNEE BRACE

Knapp Hinged Knee Orthosis with ROM

Treatment for:

Osteoarthritis Pain
 Instability/Sprain/Strain

DIAGNOSIS(ES)

Diagnosis: (please print neatly) _____

Patient's Area of Pain (Check Box):

Upper Body:

Cervical Shoulder
 Thoracic Elbow
 Lumbar Wrist
 Hip Hand

Lower Body:

Knee
 Shin
 Ankle
 Foot

Other _____

PREVIOUS TREATMENTS (check all that apply)

Prior Surgery: if yes, Date: _____ Injections NSAIDS
 Physical Therapy Pain Medications Other _____

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 ____/____/____

PRINT PHYSICIAN'S NAME: _____ UPIN # _____ NPI# _____

ADD: _____ CITY: _____ ST: _____ ZIP: _____

PHONE# (____) _____ FAX: (____) _____ EMAIL: _____

DISPENSE AS WRITTEN - ABSOLUTELY NO SUBSTITUTIONS