



Letter of Medical Necessity

Patient _____ DOB _____

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Phone # (____) _____ Fax # (____) _____

Physician Prescription

New Renewal Injury/Onset/Illness ____/____/____
Diagnosis _____ ICD9 Code ____ . ____ . ____ Diagnosis _____ ICD9 Code ____ . ____ . ____
Prognosis _____

Statement of Medical Necessity

Device: ___ Flex-IT™ ___ Flex-MT™ ___ Flex-TENS™
___ Combo Stimulator (IF 5000™) ___ Other _____
___ Flex-Gar™ (glove / sleeve / sock / back / knee /cervical/ other _____) **please check item below**

- Appropriate treatment for this condition necessitates placement of electrodes on multiple sites which may require a conductive garment
- The physical condition of this patient has resulted in restricted access to the treatment site which may require the use of a conductive garment
- The patient has a skin condition which may require conductive garment

Length of device use and supplies (indicate number of months): 1 2 3 4 5 6 7 8 9 10 11 12 indefinite

History of Treatment _____

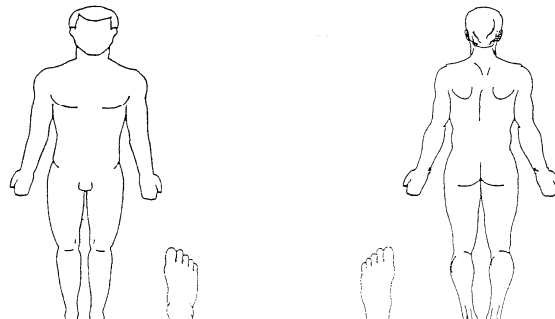
Anticipated Results from Treatment _____

Indications: (Mark all that apply)

Treatment Plan

- ___ Symptomatic chronic pain relief
- ___ Post surgical/trauma pain relief
- ___ Reduce Edema
- ___ Muscle spasm relaxation
- ___ Muscle re-education
- ___ Reduction or prevention of atrophy
- ___ Improvement of range of motion
- ___ Increase local blood circulation

Placement of Pads: Place an X to show placement of pads.



Treatment:

Frequency: _____ times daily

Treatment Time (minutes): _____

Please sign, date, and fill out the items below. Maintain a signed copy for the patient's record

In accordance with accepted medical standards, it is my opinion that the above named patient requires the device and attendant supplies for the above diagnosis. Dispense as written, no substitute permitted. If the device is purchased, I prescribe device and supplies for indefinite use.

Tax ID # _____ License # _____ Upin # _____ NPI # _____

Signature of Physician: _____ Date: _____