Pain Rehab Products, Inc.

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Prescription & Certificate of Medically Necessity

Patient's Name: _____ *Patient's DOB:* _____/_____/_____

Patient's Address: _____

Diagnosis Codes ICD-10 Primary: _____ Secondary: _____

NMES Device

☐ **Neuromuscular Stimulator - E0745**
Brand: _____
Item #: _____

Length of Need ☐(99 = lifetime) ☐Rental # _____ months

Indication for USE for E0745 (Medical Records Must Support) Check all that apply.
☐ Treatment of muscle atrophy where nerve supply to the muscle is intact, including brain,

Physician Information

I certify that the equipment and supplies I prescribed are 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 Physicians Name: _____ NPI #_____

Physician's Address: _____

Chart Notes & Rx must be submitted together, Include chart notes supporting Medical Necessity (clinical documentation must support the continued need, use and benefit the device provides) Patient Chart Notes Must Support the Following (NMES Device):

Coverage of NMES to treat muscle atrophy is limited to the treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery

Along with this copy, please fax the patient's medical records, insurance card and demographics to (314) 832-1430. Pain Rehab Products, Inc. will provide the insurance pre-certification, instructions, and supplies.