



# Pain Rehab Products, Inc.

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## Prescription & Certificate of Medical Necessity

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Address: \_\_\_\_\_

Diagnosis Codes ICD-10 Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

### TENS Unit

Transcutaneous Electrical Nerve Stimulator

Brand/Model: \_\_\_\_\_

Item #: \_\_\_\_\_

HCPCS Code: \_\_\_\_\_

Stimulator Supplies (electrodes and lead wires)

### How many months has the patient had chronic pain?

\_\_\_\_\_ (99 = lifetime; must be  $\geq 3$ )

### Length of Need:

(99 = lifetime)

Rental # \_\_\_\_\_ months

### 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: \_\_\_\_\_

### **Patient Chart Notes Must Support the Following (TENS Device):**

### **Required for ALL Medicare Patients**

- Location of Pain
- Patient has had the pain for more than 3 months
- Presumed etiology of pain cannot be TMJ, headache, abdominal/pelvic pain or lumbar condition
- Other treatment modalities have been tried, patient still has pain
- 4 Lead (8 electrodes) versus 2 lead (4 electrodes) for treat of:
  - Patient's pain covers a large area and 4 electrodes are needed to surround or treat throughout the pain area, or
  - 4 electrodes are need to treat two different pain areas or:
  - Patient has a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along pain pattern or;Other: \_\_\_\_\_

### Required for ALL Medicare Patients

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)

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. Medicare patients are required to follow up with the Physician 30 days or after they have received the device.