**Medical Record (WOPD)**

Beneficiary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FACE-TO-FACE (F2F) EXAMINATION REQUIREMENT** FACE-TO-FACE (F2F) EXAMINATION REQUIREMENT. This F2F examination must document evaluation and/or treatment of the conditions that justify the need for the item prescribed. **This visit must occur on or before the date of the prescription.**If the F2F for the equipment was performed by a physician assistant, nurse practitioner or clinical nurse specialist, the F2F must be signed by a physician before the item may be dispensed.

Location of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity of the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of time with pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presumed etiology of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATE OF MEDICAL NECESSITY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | . | **ID#:** | . |
| **Address** |  |
| **City** | . |  **State:** | . | **Zip** |  |
| **Tel#:** | . | DOB:  |  |  |  |

**FDA Indications for use (please check all that apply)**

**Disuse Atrophy ☐ Relax Muscle Spasms ☐ Muscle Re-education ☐ Increase Circulation ☐**

**Prescribed equipment**

**Conductive Garment E0731**

**Back\_\_\_\_ DX: M54.5**

**Neck\_\_\_\_ DX: M54.2**

**Shoulder\_\_\_\_ DX: M25.519**

**Vest Size\_\_\_\_\_ G89.29**

**Sock LT\_\_\_\_RT\_\_\_\_ DX: M25.579**

**Elbow LT\_\_\_\_RT\_\_\_\_ DX: M25.529**

**Glove LT \_\_\_\_\_RT\_\_\_\_\_ DX: M79.64**

**Knee Sleeve LT\_\_\_\_RT\_\_\_\_ DX: M25.569**

**Knee Support LT\_\_\_\_RT\_\_\_\_ DX:**

**Ankle LT\_\_\_\_RT\_\_\_\_ DX: M25.579**

**Replacement Pads\_\_\_\_\_\_\_\_\_\_**

**(Replacement every 3 months)**

**Conductive Spray\_\_\_\_**

**Latex allergy DX: Z91.040\_\_\_\_**

**Reduce Edema ☐ Pain Management ☐Post-Surgical Rehab ☐ Wound Therapy ☐**

**Previous \ Current Treatment**

**Medication ☐ Physical Therapy ☐ Ultra Sound ☐ Surgery ☐ Wound Dressing ☐ Whirlpool ☐Electro-Therapy ☐**

**\*The beneficiary cannot manage without the conductive garment because,**

**☐ There is such a large area or so many sites to be stimulated and**

**☐ The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes and lead wires; or**

**☐ The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or**

**☐ The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires.**

**I, the undersigned, certify that the above prescribed equipment is medically necessary for the patient’s overall well-being in my opinion; the equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient’s condition and\or rehabilitation and is not prescribed as “convenience” equipment.**

**Order Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NPI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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