PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

PATIENT'S NAME:____

1. PERIOD OF MEDICAL NECESSITY:

   a. Number of months:____

   b. Date patient was last seen:____________________________________

2. DEVICE PRESCRIBED FOR:

   ☐ RENTAL

   ☐ PURCHASE

3. a. Diagnosis:____

   b. Severity:____

   c. Prognosis:____

4. DEVICE PRESCRIBED: _☐ _GEMS-TENS ____________☐ EMS-hp _____________
   with G.E.M.S. supplies for period of medical necessity

   a. The testing performed by:______________________________________

   b. The testing DID / DID NOT give the patient significant relief of pain.

I certify under penalty of perjury that the above prescribed stimulator is medically necessary as part of my treatment program for this patient. The prescribed stimulator is reasonable and necessary to cure or relieve this patient's condition.
NO SUBSTITUTIONS / NAME BRAND ONLY.

____ ______________________________
PHYSICIAN'S SIGNATURE DATE

Physician's name:____

Address:____

City, State, Zip____

Telephone:____