PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

PATIENT'S NAME:

1. PERIOD OF MEDICAL NECESSITY:

   a. Number of months:

   b. Date stimulator dispensed to patient:

2. DEVICE PRESCRIBED FOR:

   ☐ RENTAL

   ☐ PURCHASE

3. a. ICD-10 CODES:

   b. Severity: Moderate - High

   c. Prognosis: Guarded

4. DEVICE PRESCRIBED: ☐ GEMS-TENS M4 ☐
   with "GEMS" TENS 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: _____ NPI#:_____

Address: _____

City, State, Zip: _____

Telephone: _____

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