

PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

PATIENT'S NAME: SALLY SOREBACK

1. PERIOD OF MEDICAL NECESSITY:

a. Number of months: INDEFINITE

b. Date patient was last seen: TODAY (07/15/2008)

2. DEVICE PRESCRIBED FOR:

RENTAL

PURCHASE

3. a. Diagnosis: 722.1, 729.1; 723.4

b. Severity: MODERATE - HIGH

c. Prognosis: GUARDED

4. DEVICE PRESCRIBED: GEMS-TENS EMS-hp
with G.E.M.S. supplies for period of medical necessity

a. The testing performed by: MARCUS WELBY, D.C., M.D.

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

I certify that the above prescribed GEMS-TENS is medically necessary as part of my treatment program for this patient. The prescribed GEMS-TENS is reasonable and necessary for the treatment of this patient's condition.

NO SUBSTITUTIONS.

MARCUS WELBY 7/15/2008
PHYSICIAN'S SIGNATURE DATE

Physician's name: MARCUS WELBY, D.C., M.D.

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