Wellness Electrotherapy

Your Professional answer to better Health & Wellness

Wellness Pro Electrotherapy System

Prescription & Letter of Medical Necessity

Please ensure that the information below is consistent with your patient's medical record.

PATIENT

First Name _____ Last Name _____

DOB _____ Social Security # _____

Clinic Name _____ Clinic Phone Number _____

Date of Injury/Onset _____

PRODUCT

Electromedical Technologies Products:

☐ WellnessPro 2010 - TENS ☐ Set of Accessories (big and small)

Primary ICD9 Code: _____ Secondary ICD9 Code: _____

HISTORY

PREVIOUS TREATMENT(S)/MEDICATION(S)

☐ Prior Surgery
☐ Pain Medications
☐ Injections
☐ NSAIDS
☐ Physical Therapy
☐ Other: _____

LENGTH OF NEED

LENGTH OF NEED (PLEASE CHECK ONE)

☐ Purchase ☐ 6-10 Months (Long Term Need) ☐ Rental # of Months _____

Physician Name _____ Phone Number _____

Physician's Signature _____ Signature Date _____

NPI # _____

I certify that the medical necessity information provided on this form is accurate and complete, to the best of my knowledge.

MEDICARE/MEDICAID PATIENTS

PLEASE COMPLETE THE PORTION BELOW FOR YOUR MEDICARE/MEDICAID PATIENTS

Patient is using device for: (Please check one)

☐ Acute Post Operative Pain or ☐ Chronic Intractable Pain: # of _____ months of pain

Please indicate why your patient requires a 4 Lead (4 electrodes) Device:

___ Patient's pain covers a large area and 4 electrodes are needed to surround or treat throughout the pain area

___ 4 electrodes are needed to treat 2 different areas

___ Patient is experiencing a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along the pain pattern

___ Other (please explain) _____

Therapist Name _____ Phone # _____

Fax Form to: 928 204 2957