Send to First Alternatives

Physician's Statement of Medical Necessity (Prescription)

Please Complete, Sign, Date and Fax to (772) 872-6620

Patient's Name: _____ Date of Birth: _____ SS#: _____

Patient's Address: _____

Patient's Phone #: _____

Date of Injury/Onset: _____

Diagnosis / ICD9:

___	338.4	Chronic Pain	___	719.42	Pain: Joint: Elbow	___	719.41	Pain: Joint: shoulder (region)
___	338.28	Pain: Postoperative: Chronic	___	719.47	Pain: Joint: Foot	___	719.43	Pain: Joint: wrist
___	729.5	Pain: Extremity (lower) (upper)	___	719.44	Pain: Joint: Hand	___	784.0	Pain: face, facial
___	724.5	Pain: Back (postural)	___	719.45	Pain: Joint: Hip	___	350.2	Pain: face, facial: Atypical
___	724.2	Pain: Back: Low	___	719.46	Pain: Joint: Knee	___	351.8	Pain: face, facial: Nerve
___	719.40	Pain: Joint	___	719.49	Pain: Joint: Multiple Sites	___	729.5	Pain: Finger
___	719.47	Pain: Joint: Ankle	___	719.45	Pain: Joint: Pelvic Region	___	729.5	Pain: Foot
						___	729.5	Pain: Hand

Other ICD-9 Codes: _____

Other Diagnosis : _____

Previous Treatment(s)/Medications: _____

Product Description:

Micro-current Biofeedback TENS BEST RSI™ or BEST-PRO 1™ Device with lead wire, & Conductive Pads

Conductive Garment ___ is, ____ is not medical necessity. Check any that apply:

___ large area to be treated
___ multiple sites to be treated
___ areas are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
___ medical conditions, such as skin problems, that preclude the application of conventional electrodes
___ therapy required beneath a cast

☐ Left	☐ Carpal wrap	☐ elbow wrap	☐ conductive glove
☐ Right	☐ ankle wrap	☐ shoulder wrap	☐ conductive sleeve
☐ Both	☐ low back wrap (6 inches tall)	☐ arm or leg wrap	☐ conductive sock
	☐ high back wrap (8 inches tall)	☐ cervical wrap	☐ conductive leg sleeve

Length of Need:

_____# of Months (short term) _____9 months or longer (long term) _____Purchase

I certify that the above prescribed treatment is medically necessary for the patient's well being. In my opinion, the treatment is effective and is reasonable in the treatment of this patient's condition. I also certify that the information noted above is accurate to the best of my knowledge.

Physician's Signature:_____ Date:_____

Physician's Name (print):_____ NPI number:_____

Clinic Name: _____ Phone#: _____

Physician's Address:_____

DO NOT SUBSTITUTE CONFIDENTIAL INFORMATION