First Alternatives
8240 SW Cattleya Drive
Stuart, FL 34997

First Alternatives
"Life Without Pain"

Statement of Medical Necessity (Prescription)

Patient's Name: ______________________________ Date of Birth: ______________

Patient's Address: ______________________________

Patient's Phone Number: ______________________________

Date of Injury/Onset: ______________________ **Date of Last Office Visit:** ______________________

Diagnosis / ICD10:

___ G89.29 Chronic Pain
___ M54.9 back pain
___ M54.5 Lumbar region pain
___ M25.551/M25.552 R / L Pain: Joint: Hip
___ M79.604/M79.605 R / L Pain: Joint: Leg
___ M25.511/M25.512 R / L Pain: Joint: Shoulder (region)
___ M25.561/M25.562 R / L Pain: Joint: Knee
___ M25.571/M25.572 R / L Pain: Joint: Ankle
___ M79.671/M79.672 R / L Pain: Joint: Foot
___ M25.531/M25.532 R / L Pain: Joint: Wrist
___ M25.521/M25.522 R / L Pain: Joint: Elbow
___ M79.601/M79.602 R / L Pain: Arm
___ M79.641/M79.642 R / L Pain: Hand
___ M79.644/M79.645 R / L Pain: Fingers
___ R10.2 Pain: Joint: Pelvic Region
___ G50.1 Pain: Face: Facial, Atypical

Other ICD-10 Codes: ______________________________

Other Diagnosis: ______________________________

Previous Treatment(s)/Medications (include dosage if medication):______________________________

____

Results: Check the one that applies:
_________ Previous treatments were sufficiently effective.
_________ Previous treatments failed and were not sufficiently effective.

Product Description:

Microcurrent TENS Device: PRO-SPORT Ultra™, BEST-RSI™, BEST PRO-1™, Avazzia Blue™ device with lead wire and conductive pads
Conductive garment ______ is ______ is not medical necessity. Check all 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
○ Right
○ Both

○ Carpal Wrap
○ Ankle Wrap
○ Low Back Wrap (6 In Tall)
○ High Back Wrap (8 in Tall)

○ Elbow Wrap
○ Shoulder Wrap
○ Arm or Leg Wrap
○ Cervical Wrap

○ Conductive Glove
○ Conductive Sleeve
○ Conductive Sock
○ Conductive Leg Sleeve

Length of Need: ______Number 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 Number: ______________

Physician's Address: ______________________________

DO NOT SUBSTITUTE **CONFIDENTIAL INFORMATION**

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