Patient Direct Agreement: Electrotherapy

Prescription/Assignment of Benefits/Letter of Medical Necessity

FAX TO: ______________

Please provide the information requested below and complete the form in full.

Clinic Information

Clinic Name ______________ Acct# ______________ Phone ______________ Fax ______________

Clinic Address ______________ City ______________ State ______ Zip ______________ Contact ______________

Sales Representative ______________ Territory # ______________ Phone ______________

Dispense Method ☐ Ship device to Patient's home address ☐ Ship Device to Clinic

Patient Assignment of Benefits/ Release of Information

☐ Private ☐ Medicare ☐ Workers Compensation ☐ Self Pay ☐ Medicaid ☐ Auto: Date of Injury ______________

Patient Name ______________ Date of Birth ______________ SS# ______________

Address ______________ City ______________ State ______ Zip ______________

Phone ______________ Alt Phone ______________ Email ______________

Insurance ______________ Policy/Claim # ______________ Group # ______________

Insured's Name ______________ Emergency Contact Name/Phone ______________

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice, and Terms and Conditions of Agreement.
By signing below, I authorize Empi to submit a claim for such product(s) to my insurer on my behalf and assign the benefits payable by my insurer to Empi. I authorize my Health care Provider and Empi to release any of my medical information required by my insurer to process the claim. I understand that Empi does not waive patient balances and that I am responsible for and agree to pay any portion of the amount due for such product(s) not paid for by my insurer, whether resulting from deductibles, co-pays, determination of non-coverage, or otherwise. I understand that the Patient Bill of Rights and Responsibilities, the CMS Medicare Supplier Standards and the Empi Notice of Privacy Practices are included in the device package and that I can contact customer service at 800-328-2536 if I have questions about the documents.

*Patient Signature ______________ Date of Signature ______________
*REQUIRED FOR HOME DELIVERY

Guarantor/Legal Rep (if patient unable to sign): ______________

Relationship to Patient ______________ Date ______________

Prescription

DEVICE REQUESTED:

- ☐ **Empi ACTIVE™ TENS Back and Supplies**
- ☐ **Empi ACTIVE™ TENS Knee and Supplies**
- ☐ **Empi ACTIVE™ TENS Shoulder and Supplies**
- ☐ **Select™ TENS and Supplies**
- ☐ **Continuum and Supplies**
- ☐ **Other** ______________
- ☐ **EasyWear Garment**
- ☐ **IF3Wave® and Supplies**

MEDICAL NECESSITY / LENGTH OF NEED

☐ Purchase (99 = Lifetime) ☐ Rental # ______ months **ICD9 CODES** ______________ ______________
Primary ICD-9 Code Secondary ICD-9 Code

Previous Treatment(s)/ Medications: ☐ **Prior Surgery** ☐ **NSAIDS/ Pain Medications** ☐ **Physical Therapy** ☐ **Injections**
☐ **Other** ______________

Primary Indication For Use - **Completion Required for Neuromuscular Stimulator (NMES) (Check One)**
☐ Retard disuse atrophy/muscle weakness ☐ Re-educate muscles ☐ Relax muscle spasms ☐ Pain control

TENS — Medicare/Medicaid Completion Required

Medicare requires that we maintain documentation supporting a patient's need for two-channel (4 lead) TENS device. In addition, the supplier must substantiate that the patient has chronic intractable pain and the duration of this pain.

Patient is using for (check one): ☐ Chronic Intractable Pain ☐ Acute Post Op

HOW MANY MONTHS HAS YOUR PATIENT HAD CHRONIC INTRACTABLE PAIN (99=LIFETIME): ______________

Justification for 4 leads (2 channel) versus 2 leads (1 channel)

- ☐ 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 two different pain areas.
- ☐ Patient has a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along pain pattern.
- ☐ Other: ______________

Empi EasyWear Garment – Medicare/Medicaid Completion Required

Patient has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes and leadwires. *If yes, please attach the patient's medical record as supporting documentation.* ☐ Yes ☐ No

Physician Name: ______________ NPI#: ______________ Phone: ______________

*Physician Signature: ______________ Date of Signature: ______________

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. Please make sure the above information is substantiated in your patient's medical record.

*Signature stamps are not permitted for Medicare.

DO NOT SUBSTITUTE

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