17 Charles Street
Binghamton, NY 13905
607-584-5560 ext 231
Fax: 607-584-5561

# Instructions for Obtaining a Tens Unit or Cervical Traction

1. Have the patient complete and sign the Pre-Cert Form.

2. Fax the form & Rx to Rehab Supply at 607-584-5561 or 607-772-2455

3. If the patient has an out of pocket cost, Rehab Supply will contact the patient to inform them. The patient must confirm with Rehab Supply that it is ok to send the unit once out of pocket costs are discussed with the patient. If a voicemail is left for the patient, and the call is not returned to Rehab Supply, the unit will not be sent until we speak with the patient.

4. If the patient doesn't have any out of pocket costs the unit will be automatically shipped to the patient.

5. The patient will typically receive the unit within 2-3 business days of the referral being sent to us, unless they fail to return our call to discuss out of pocket costs.

17 Charles Street, Binghamton, NY 13905 - Phone: (800)485-9717
**Fax request to (607)584-5561 or (607)772-2455**

# Pre-Cert Form

## *Referral Information*

Clinic Name_____Contact Person_____

## *DME Device Request*

☐ TENS
☐ TENS/ IF COMBO
☐ EMS
☐ TWINSTIM
☐ INTERFERENTIAL
☐ CONDUCTIVE GARMENT
**BODY PART** _____

☐ LSO BRACE
☐ L0642 ☐ L0648
☐KNEE BRACE
☐WRIST BRACE
☐ANKLE BRACE
☐SHOULDER BRACE

☐CERVICAL TRACTION

Anticipated length of need 99 months or _____months

Unit Training provided by: _____

*******************Prescription should be included with Authorization Request*******************

**Once eligibility checked patient will be called if any financial responsibility. Unit will be shipped to patient's home via USPS.**

## Rental/Sales Agreement /Assignment of Benefits/Release of Information

## *Patient Contact Information*

Last Name_____ First Name_____ Middle Name _____ DOB_____

Street _____City_____State_____Zip_____

Home Phone #_____ Cell Phone #_____E-mail _____

Mailing address (if different than above) _____

Emergency Contact _____Relationship: _____Phone#_____

## *Patient Insurance Information* *(include copy of cards whenever possible)*

Primary Ins. Carrier_____ Phone #_____Policy/Claim# _____

Street _____City_____State_____Zip_____

Secondary Ins. Carrier _____ Phone #_____Policy/Claim# _____

Street _____City_____State_____Zip_____

## *Below information must also be included for Work Comp/Auto Insurance*

Date of Injury_____ State of Accident (Auto) _____Employer (WC): _____

Social Security #_____ Adjustor/Case Mgr Name_____ Phone #_____

## *Patient Acknowledgment that all the information is complete & accurate*

I hereby acknowledge that I agree with the 10 points of the Rehab Supply Patient Awareness Sheet provide under separate cover. I have received Rehab Supply's Important Client Information & Right Sheet that details my Bill of Rights, Notice of Privacy Practices, CMS Supplier Standards, and Rehab Supply Payment & Return Policies. If I have any questions, I may contact Rehab Supply at 800-485-9717 ext 231. I have filled in all the patient information and written "none" in any empty space. I have been trained on the use of the item.

**Patient Signature** _____ **Date** _____

Guarantor/Legal Representative _____ Date _____
(Required if patient is unable to sign or under 18 yr of age)