Rx – Prescription & Letter of Medical Necessity

17 Charles St.
Binghamton, NY 13905
800-485-9717
607-584-5560 ◈ Fax 607-584-5561

Patient:

_____ _____
First Name Last Name

_____ _____ _____
DOB Social Security # Phone #

Modality: **DO NOT SUBSTITUTE**

- ☐ **REHAB 4 Plus** – IFC 4 channel
- ☐ **REHAB 2 Plus** – IFC 2 channel
- ☐ **ReliaMed –** TENS
- ☐ **TENS 3000** – TENS
- ☐ **ReliaMed -** EMS
- ☐ **Other** _____
- ☐ **Smart WaveGS** - HVPGS
- ☐ **System-Loc -** LSO
- ☐ **Quickdraw RAP** - LSO
- ☐ **TENS 7000 -** TENS
- ☐ **Twin Stim –** EMS / TENS Combo

Diagnosis:
Primary Diagnosis: _____ ICD-9 Code _____
Secondary Diagnosis: _____ ICD-9 Code _____

Medical Necessity:

- ☐ Inhibit intractable pain
- ☐ Stimulate muscle contractions
- ☐ Prevent disuse atrophy
- ☐ Re-educate muscles
- ☐ Trigger point therapy
- ☐ Break muscle spasms
- ☐ Increase range of motion
- ☐ Increase blood flow
- ☐ Reduce edema from trauma/post-op procedures
- ☐ Increase venous return to prevent deep vein thrombosis
- ☐ Other (please print) _____

Length of Need:

- ☐ **Long-term use**
- ☐ _____# of months, purchase if effective
- ☐ 6-9 months

Physician Signature:

_____ _____
Physician Name Phone #

_____ _____
UPIN # FAX #

☐ **No Substitutions –** In my opinion, in accordance with accepted medical practice standards, the above named patient requires the Rehab Supply device (no substitutions allowed) and required supplies as dispensed by Rehab Supply, for the problems identified above.

_____ _____
Physician's Signature (remember to check no substitutions box) Date