Prescription & Letter / Certificate of Medical Necessity

Zynex Medical
(P) 800-495-6670
(F) 800-495-6695

Patient Name:	Date of Birth MM/DD/YY	SS #:
Patient Home Phone #:	Insurance	
Clinic Name & Phone #:	Date of Incident: MM/DD/YY _____/_____/_____	

ELECTROTHERAPY

Length of Need (required):

☐ Purchase ☐ Long-term ☐ 6-9 mos ☐ 3-6 mos

Low Back Pain

☐ Patient requires a **conductive garment** to treat the area of chronic intractable pain because the area is inaccessible with conventional electrodes.

LSO SPINAL ORTHOSIS

☐ LSO - Lumbar Sacral Orthosis

Treatment for:

☐ Post Surgical Lumbar Sacral Stabilization

☐ Chronic Back Pain

KNEE BRACE

☐ Knapp Hinged Knee Orthosis with ROM

Treatment for:

☐ Osteoarthritisis Pain

☐ Instability/Sprian/Strain

DIAGNOSIS(ES)

Diagnosis: (**please print neatly**)_____

Patient's Area of Pain (Check Box):

Upper Body: ☐ Cervical ☐ Thorasic ☐ Lumbar ☐ Hip ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

Lower Body: ☐ Knee ☐ Shin ☐ Ankle ☐ Foot

☐ Other_____

PREVIOUS TREATMENTS (check all that apply)

☐ Prior Surgery: if yes, Date: _____ ☐ Injections ☐ NSAIDS

☐ Physical Therapy ☐ Pain Medications ☐ Other_____

PHYSICIAN INFORMATION

I certify that the equipment and supplies I prescribed is Medically Necessary for this patient's well-being. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. It is NOT prescribed as convenience equipment.

Substitution for this device is *NOT ALLOWED* without my written approval.

PHYSICIAN'S SIGNATURE _____DATE _____/_____/_____

PRINT PHYSICIAN'S NAME: _____ UPIN # _____ NPI#_____

ADD: _____CITY: _____ST: _____ ZIP: _____

PHONE# (_____) _____ FAX: (_____) _____ EMAIL: _____

DISPENSE AS WRITTEN - ABSOLUTELY NO SUBSTITUTIONS