

Effective 10/93

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 06.01

CERTIFICATE OF MEDICAL NECESSITY: TENS

SECTION A CERTIFICATION: INITIAL REVISED

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(____) _____ HICN _____

(____) _____ NSC _____

PLACE OF SERVICE _____ REPLACEMENT ITEM _____

HPCS CODE(S) _____ WARRANTY _____ LENGTH _____ TYPE _____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

SECTION B INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE

DIAGNOSIS (ICD9): _____

DOB ____/____/____

I LAST EXAMINED THIS PATIENT FOR THIS
CONDITION ON: ____/____/____ PT. SEX ____ (M OR F)

DATE NEEDED INITIAL ____/____/____ REVISED ____/____/____
EST. LENGTH OF NEED: # OF MONTHS: ____ 1-99 (99 = LIFETIME)

ANSWER QUESTIONS 1-6 FOR RENTAL OF TENS, AND 3-12 FOR PURCHASE OF TENS Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

[] 1. Does the patient have acute post-operative pain?

8. What are the dates that trial of TENS unit began and ended?

2. What is the date of the surgery resulting in acute post-operative pain?
____/____/____

____/____/____ to ____/____/____

9. What is the date that you reevaluated the patient at the end of the trial period?
____/____/____

[] 3. Does the patient have chronic, intractable pain?

10. How often has the patient been using the TENS?

4. How long has the patient had intractable pain?
Enter number of months 1-99.

- 1 = Daily
- 2 = 3 to 6 days per week
- 3 = 2 or less days per week

5. For which, if any, of the following conditions is the TENS unit being prescribed?

- 1 - Headache
- 2 - Visceral abdominal pain
- 3 - Pelvic pain
- 4 - Temporomandibular joint (TMJ) pain
- 5 - None of the above

[] 11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is warranted?

[] 6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?

12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time:
2 = 2 Leads
4 = 4 Leads

[] 7. Has the patient received a TENS trial?

I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

PHYSICIAN'S SIGNATURE: _____ DATE _____
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

Attending Consulting Other ordering

UPIN: _____

TELEPHONE #: (____) _____