Insurance Covered
TENS UNITS

**Physician Prescription**
**Phone: 888-510-5100 • Fax: 309-664-7931**
**Email: orders@insurancecoveredtensunits.com**

Patient Name: _____ DOB: _____

Address: _____

Email: _____ Phone: _____

Insurance Company: _____ Insurance Policy #: _____

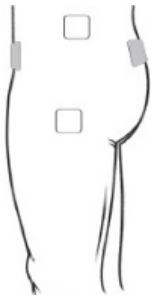
## PRESCRIPTION / MEDICAL NECESSITY

☐ TENS Unit / Monthly Supplies - 4 Lead

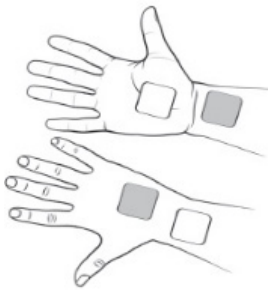
Length of Need: Lifetime (unless noted otherwise)

How many months has your patient had chronic intractable pain (99=Lifetime)? _____

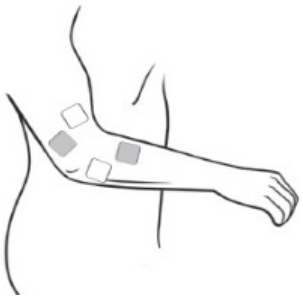
**INSTRUCTIONS:** Apply electrodes to the affected area and use device to relieve pain as needed



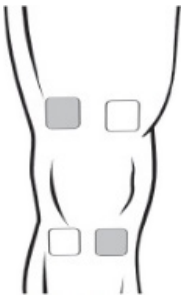
☐ Hip Pain



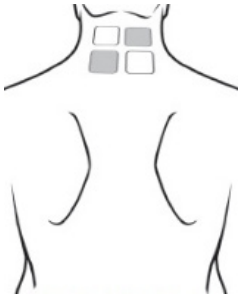
☐ Carpal Tunnel



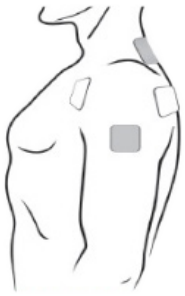
☐ Elbow Pain



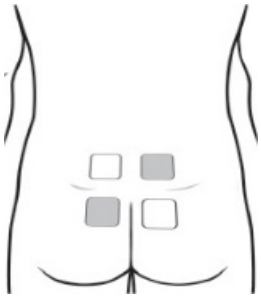
☐ Knee Pain



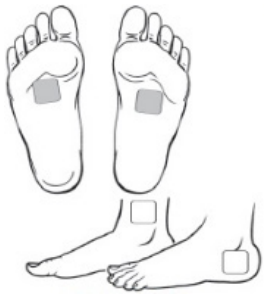
☐ Cervical Pain



☐ Shoulder Pain



☐ Lumbar Pain



☐ Foot Pain

**ICD-10 CODES:** _____ _____ ☐ **Right** ☐ **Left**
Primary ICD-10 Code Secondary ICD-10 Code

Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

*I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.*

**PLEASE EMAIL OR FAX THIS PRESCRIPTION WITH PATIENT INSURANCE / DEMOGRAPHICS**