DC Medical Equipment, LLC

Certificate of Medical Necessity:

Personal Information:
Patient Name: ________________________________ Date of Birth: ___________________
Social Security #: __________________ Date of Injury/Onset of Symptoms: ______________
Phone: ________________________ Email: _______________________________________
Address: ___________________________________ State, City, Zip:___________________

Prescription:
□ E0730 – TENS Unit □ L0627 – Lumbar Brace (Waist Size: ______)

Length Required: □ 12+ months (longterm/chronic use) □ #________ months (1-11)

ICD-9 Diagnosis Codes:

_______________	_______________	_______________	_______________
Primary	*Secondary*	*Tertiary*	*Quaternary*

Previous Medical Treatment History/Medications: (check all that apply)
□ Prior Surgery □ Pain Meds/NSAIDS □ Physical Therapy □ Injections
□ Other ____
Names of medications used (if checked):____

Primary Indication for use: (check all that apply)
□ Decrease/stop muscle atrophy □ Decrease/stop muscle weakness □ Relax muscle spasms
□ Stimulate muscle contractions □ Increase range of motion □ Pain control
□ Re-educate muscles □ Reduce edema □ Reduce hypertonicity □ Manage chronic pain
□ Other ____

Pain Severity: Chronic Severe Intractable Mild Moderate

Date of Initial Visit:______________________ **Date of Last Visit:**______________________

By signing below, I am prescribing the item(s) checked above and certify that the above-prescribed device is mecically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition because: (please explain why device is necessary, which is indicated and supported in the patient's medical records)

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Physician Name (print): ______________________________________ NPI: _____________

Physician Signature: ____ Date: ___________

Please fax completed form to 847.677.9356 or email to customersupport@dcmedequip.com

* 1164 W. Madison St. #307 * Chicago, IL 60607 * (PH) 630.675.8515 *
customersupport@dcmedequip.com