

DC Medical Equipment, LLC

Invoice for Services Rendered:

Physician: _____ Clinic: _____

Patient Name: _____ Date: _____

Upon receipt of this invoice, DCME will issue a fee for evaluation, instruction/ training and fitting of the prescribed medical equipment.

Equipment Prescribed to Patient:

Tens Unit Lumbar Brace Cervical Traction Unit

Services Performed By Physician:

Administrative:

Made a recommendation based on medical necessity to patient for durable medical equipment. Conveyed rights and obligations to patient. Served as a point of distribution for products prescribed.

Instruction/Training:

Instructed and trained the patient on the proper usage and function of the equipment prescribed. For TENS Unit, this includes electrode placement, settings and care of the electrodes. Covered all warnings and contraindications of the equipment with the patient.

Future Care/Observation:

Will continue to monitor patient progress and compliance with equipment prescribed. Will perform a re-evaluation after 30 days.

The equipment prescribed to this patient was based only on medical necessity. I agree to provide any supporting documentation, including progress notes, treatment plan, medical records, in order to verify medical necessity.

I certify by checking the boxes above that all services were performed.

Patient Signature: _____ Date: _____