Patient Direct Agreement: Electrotherapy

Prescription/Assignment of Benefits/Letter of Medical Necessity

FAX TO:

Please provide the information requested below and complete the form in full.

Clinic Information

Prescribing Provider's Office _____ Acct# _____ Phone _____ Fax _____

Clinic Address _____ City _____ State _____ Zip _____ Contact _____

Sales Representative _____ Territory # _____ Phone _____

Ship Method ☐ Clinic ☐ Home ☐ Standard (3-5 days—no fees) Fees for expedited home delivery: ☐ 2 day ($19.99) ☐ Next Day ($29.99) (+ tax if applicable)

NOTE: Default shipment is ground if the patient's credit card information is not secured. **Best number and time between business hours of 8-5 CST to reach patient to obtain payment for delivery upgrade _____

***Fees N/A for Work Comp, Medicare or Medicaid

Indicate where Medicare patient received this product:

☐ Patient's Home ☐ Prescribing Provider's Office ☐ Physical Therapy Clinic ☐ Other: _____

(To be completed by the sales representative. Address must be included)

Patient Assignment of Benefits/ Release of Information

☐ Private ☐ Medicare ☐ Workers Compensation ☐ Self Pay ☐ Medicaid ☐ Auto: Date of Injury _____

Patient Name _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Alt Phone _____ Email _____

Insurance _____ Policy/Claim # _____ Group # _____

Insured's Name _____ Emergency Contact Name/Phone _____

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice, and Terms and Conditions of Agreement.
By signing below, I authorize Empi to submit a claim for such product(s) to my insurer on my behalf and assign the benefits payable by my insurer to Empi. I authorize my Health care Provider and Empi to release any of my medical information required by my insurer to process the claim. I understand that Empi does not waive patient balances and that I am responsible for and agree to pay any portion of the amount due for such product(s) not paid for by my insurer, whether resulting from deductibles, co-pays, determination of non-coverage, expedited shipping or otherwise. I understand that the Patient Bill of Rights and Responsibilities, the CMS Medicare Supplier Standards and the Empi Notice of Privacy Practices are included in the device package and that I can contact customer service at 800-328-2536 if I have questions about the documents.

*Patient Signature _____ Date of Signature _____

*REQUIRED FOR HOME DELIVERY

Guarantor/Legal Rep (if patient unable to sign): _____

Relationship to Patient _____ Date _____

Prescription

DEVICE REQUESTED:

☐ **Empi ACTIVE™ TENS Back and Supplies**
☐ **Empi ACTIVE™ TENS Knee and Supplies**
☐ **Empi ACTIVE™ TENS Shoulder and Supplies**
☐ **Select™ TENS and Supplies**
☐ **Continuum and Supplies**
☐ **Empi Axon and Supplies**
☐ **EasyWear Garment**
☐ **IF3Wave® and Supplies**
☐ **Other** _____

MEDICAL NECESSITY / LENGTH OF NEED

☐ Purchase (99 = Lifetime) ☐ Rental # _____ months **ICD9 CODES** _____ (Primary ICD-9 Code) _____ (Secondary ICD-9 Code)

Previous Treatment(s)/ Medications: ☐ **Prior Surgery** ☐ **NSAIDS/ Pain Medications** ☐ **Physical Therapy** ☐ **Injections**
☐ **Other** _____

Primary Indication For Use - Completion Required for Neuromuscular Stimulator (NMES) (Check One)

☐ Retard disuse atrophy/muscle weakness ☐ Re-educate muscles ☐ Relax muscle spasms ☐ Pain control

TENS — Medicare/Medicaid Completion Required

Medicare requires that we maintain documentation supporting a patient's need for two-channel (4 lead) TENS device. In addition, the supplier must substantiate that the patient has chronic intractable pain and the duration of this pain.

Patient is using for (check one): ☐ Chronic Intractable Pain ☐ Acute Post Op

HOW MANY MONTHS HAS YOUR PATIENT HAD CHRONIC INTRACTABLE PAIN (99=LIFETIME): _____

Justification for 4 leads (2 channel) versus 2 leads (1 channel)

☐ Patient's pain covers a large area and 4 electrodes are needed to surround or treat throughout the pain area.
☐ 4 electrodes are needed to treat two different pain areas.
☐ Patient has a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along pain pattern.
☐ Other: _____

Empi EasyWear Garment – Medicare/Medicaid Completion Required

Patient has a documented medical condition such as skin problems that preclude the application ☐ Yes ☐ No
of conventional electrodes, adhesive tapes and leadwires. *If yes, please attach the patient's medical record as supporting documentation.*

Physician Name: _____ NPI#: _____ Phone: _____

*Physician Signature: _____ Date of Signature: _____

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. Please make sure the above information is substantiated in your patient's medical record.

*Signature stamps are not permitted for Medicare. DO NOT SUBSTITUTE

Empi, Inc. • 205 Hwy, 22 East • Clear Lake, SD 57226