

CERTIFICATE OF MEDICAL NECESSITY

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A		Certification Type/Date: _____	INITIAL ___/___/___	REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER		
(____) _____ - _____ HICN _____		(____) _____ - _____ NSC # _____		
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____	PT DOB ___/___/___; Sex ___ (M/F); HT. ___(in.); WT. ___(lbs.)		
		PHYSICIAN NAME, ADDRESS (Printed or Typed)		
		PHYSICIAN'S UPIN: _____		
		PHYSICIAN'S TELEPHONE #: (____) _____ - _____		

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1 - 6 FOR RENTAL OF TENS, AND 3 - 12 FOR PURCHASE OF TENS. (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)	
Y N D	1. Does the patient have acute post-operative pain?	
___/___/___	2. What is the date of surgery resulting in acute post-operative pain?	
Y N D	3. Does the patient have chronic, intractable pain?	
[___ months]	4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)	
1 2 3 4 5	5. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above	
Y N D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?	
Y N D	7. Has the patient received a TENS trial?	
Began/Ended ___/___/___ ___/___/___	8. What are the dates that trial of TENS unit began and ended?	
___/___/___	9. What is the date that you reevaluated the patient at the end of the trial period?	
1 2 3	10. How often has the patient been using the TENS? (Circle appropriate number) 1 = Daily 2 = 3 to 6 days per week 3 = 2 or less days per week	
Y N D	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?	
2 4	12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time: (Circle appropriate number) 2 = 2 leads 4 = 4 leads	

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)