



Patient's Name*: _____ Patient's Phone*: _____

Patient's Address: _____

Patient's Email Address: _____

Clinic Name: _____ Clinic Phone: _____

Indications For Use: Pain Control

Primary ICD-10 Code*: _____

Secondary ICD-10 Code: _____

Date of Injury/Onset: _____

Previous Treatment(s)/Medication(s):

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Prior Surgery | <input type="checkbox"/> NSAIDs | <input type="checkbox"/> Pain Medications |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Injections | <input type="checkbox"/> Other: _____ |

Length of Need:

- Purchase (Lifetime) 6-10 Months (Long Term Need): _____ # of Months

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge. **DO NOT SUBSTITUTE**

Physician's Name (Print)*: _____ Phone*: _____

Physician's Signature*: _____ Signature Date*: _____

Please make sure the above information is substantiated in your patient's medical record.

FAX FORM TO: 480.452.1518

MDS-2539