AVAZZIA
Innovation in Health & Wellness Technology

Physician's Statement of Medical Necessity (Prescription)

Please complete, sign, date and fax to (214) 575-2824

Patient's Name: _____Date of Birth: _____

Patient's Address: _____

Patient's Phone Number: _____

Date of Injury/Onset: _____ Date of Face-to-Face Examination within past 6 months: _____

Diagnosis / ICD-10 that the patient was evaluated and/or treated for:

___ G89.29 Chronic Pain
___ M54.9 back pain
___ M54.5 Lumbar region pain
___ M25.551/M25.552 R / L Pain: Joint: Hip
___ M79.604/M79.605 R / L Pain: Joint: Leg
___ M25.511/M25.512 R / L Pain: Joint: Shoulder (region)
___ M25.561/M25.562 R / L Pain: Joint: Knee
___ M25.571/M25.572 R / L Pain: Joint: Ankle
___ M79.671/M79.672 R / L Pain: Joint: Foot
___ M25.531/M25.532 R / L Pain: Joint: Wrist
___ M25.521/M25.522 R / L Pain: Joint: Elbow
___ M79.601/M79.602 R / L Pain: Arm
___ M79.641/M79.642 R / L Pain: Hand
___ M79.644/M79.645 R / L Pain: Fingers
___ R10.2 Pain: Joint: Pelvic Region
___ G50.1 Pain: Face: Facial, Atypical

Other ICD-10 Codes: _____

Other Diagnosis: _____

Previous Treatment(s)/Medications (include dosage if medication):_____

_____

Results: Check the one that applies: _____ Previous treatments were sufficiently effective.
_____ Previous treatments failed and were not sufficiently effective.

Product Description:
Microcurrent biofeedback TENS BEST PRO-1™ device with lead wire and conductive pads

Conductive garment _____ is _____ is not medical necessity. Check all that apply:

___ Large area to be treated
___ Multiple sites to be treated
___ Areas are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
___ Medical conditions, such as skin problems, that preclude the application of conventional electrodes
___ Therapy required beneath a cast

◯ Left
◯ Right
◯ Both

◯ Carpal Wrap
◯ Ankle Wrap
◯ Cervical Wrap

◯ Elbow Wrap
◯ Shoulder Wrap
◯ Arm or Leg Wrap

◯ Conductive Glove
◯ Conductive Sleeve
◯ Conductive Sock
◯ Conductive Leg Sleeve

Length of Need: _____Number of months (short term) _____9 months or longer (long term) _____Purchase

I certify that the above prescribed treatment is medically necessary for the patient's wellbeing. In my opinion, the treatment is effective and is reasonable in the treatment of this patient's condition. I also certify that the information noted above is accurate to the best of my knowledge.

Physician's Signature: _____Date:_____

Physician's Name (print):_____NPI number:_____

Clinic Name: _____ Phone Number: _____

Physician's Address: _____

DO NOT SUBSTITUTE **CONFIDENTIAL INFORMATION**

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