Rx T.E.N.S. Device Prescription

Letter of Medical Necessity

PATIENT INFORMATION / HIPPA / Assignment of Benefits / Release of Information

Patient Name (Print):_____ DOB: _____

Primary Phone:_____ Email or Secondary Phone:_____

By signing below, I hereby authorize MSP (Medical Science Products, Inc.) to submit a claim for such product(s) to my insurer on my behalf and assign the benefits payable by my insurer to MSP. I authorize my healthcare provider and MSP to release any of my medical information required by my insurer to process the claim. I authorize any holder of Medical Information about me to release to MSP, my physician (s), caregiver, CMS or its agents. I understand that MSP 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, and determination of non-coverage or otherwise. MSP may contact me by telephone or mail. The Patient Bill of Rights and Responsibilities, 30 Medicare Supplier Standards, Complaint Process, Warranty and the HIPAA Notice of Privacy Practices are included in the device package. I have received User Instruction / Plan of Care on the product I have received. I understand that I can contact customer service at 1-800-456-1971 if I have any questions about the documents.

Medicare patients without secondary insurances may incur out of pocket expenses that will not exceed: TENS unit purchase $16.00, TENS unit rental $2.00, TENS supplies per month $5.00. This is your medicare co-insurance/capped rental agreement.

X Patient Signature: _____ **Date:** _____

DEVICE PRESCRIBED

❑ **MSP-TENS with TENS Supplies** (E0730) Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, 2 leads are insufficient for multiple nerve stimulation of chronic intractable pain duration greater than 6 months

❑ **Conductive Stim Garment** (E0731) for use with MSP-TENS applicable due to patient skin condition/allergy or large inaccessible treatment site

Check the following for prescribed device

Associated Diagnosis ICD-10 code _____ . _____

Condition Duration ❑ greater than 6 months___

Length of Need ❑ Lifetime Treatment(99) ❑ Other: _____

Treatment Site ❑ Cervical ❑ Thoracic ❑ Shoulder ❑ Hip ❑ Knee ❑ Hand ❑ Foot ❑ Other _____

Treatment Frequency ❑ BID ❑ TID ❑ Other_____

❑ **MSP-TENS Supplies Only** ❑ **Other Device** _____
(See MSP Product Guide)

PRESCRIBER INFORMATION

Prescriber name (Print):_____ NPI#: _____

I certify that the equipment and supplies prescribed above are Medically Necessary for this patient. In my professional opinion the equipment is both Reasonable and Necessary in reference to the accepted standards of medical practice and treatment of this patient's condition. DAW.

❑ Accept Electronic Signature

X Physician Signature _____ Date _____

MSP

MEDICAL SCIENCE PRODUCTS, INC.

REFER YOUR PATIENTS
BY FAXING OR EMAILING:

1. **Patient demographics**
2. **Prescription**
3. **Chart notes**

email: **info@MedSciencePro.com**
fax: **330-854-1953**

Clinic Name:

Phone #:

Address:

(Stamp Accepted)