INCLUDE PATIENT DEMOGRAPHICS & CHART NOTES

Physician Name			**NPI**
Address			Phone
City	State	Zip	Fax

Patient Name	**D.O.B**
Phone	Mobile

PRESCRIBED PELVIC FLOOR STIMULATOR

Zynex InWave Pelvic Floor Stimulator & Probe

Please Indicate The Following:

LON: ☐ **3-10 Months** ☐ **Lifetime**

DX: ☐ **N39.41 Urge IC** ☐ **N39.3 Stress IC** ☐ **N39.46 Mixed IC** ☐ **Other** _____

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's condition, this is NOT prescribed as convenience equipment. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition.

Substitution for this device is *NOT ALLOWED without my written approval.*

Provider Signature _____ **Date** _____

No Signature Stamps

Please Fax To: (866) 888-8888 **Rep Name**

See back for additional REQUIRED Documentation to be submitted with this Rx