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: (855) 845-5941 **Email to: orders@zynex.com**

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

REQUIRED DOCUMENTATION

CHART NOTES MUST **SUPPORT** THE FOLLOWING:

- No clinically significant improvement after completing a 4 week Pelvic Muscle Exercise program designed to increase periurethral muscle strength.
- The continued need, use and benefit of using the pelvic floor stimulator
- That the pelvic floor stimulator was prescribed for home use and dated the same date or earlier as the prescription
- The Patient must have a documented face-to-face office visit with the prescriber and discussed the medical necessity of the pelvic floor stimulator being prescribed

*PLEASE FAX CHART NOTES **WITH** THE PRESCRIPTION*