Rx Prescription & Letter of Medical Necessity

Patient Name* | DOB* | Date of Injury | Date of Surgery

Primary Phone* | Secondary Phone/ Email | Primary Language (If Not English)

Insurance Type

☐ Work Comp ☐ TRICARE ☐ Auto/Attorney/PI ☐ Commercial ☐ Medicare/Medicaid ☐ Uninsured

(e.g.- UHC,BCBS,Cigna,Aetna,etc.)

E-Stim

☐  Zynex NexWave + Monthly Supplies and a Conductive Garment when applicable

Length of Need: (if unchecked = Lifetime of Treatment) ☐ Lifetime of Treatment ☐ 3-18 Months

☐  Zynex E-Wave (NMES Only) + Monthly Supplies

☐  Zynex InWave + Probe

DX Code(s) _____.____ _____.____

Treatment Area: ☐ Neck ☐ Shoulder ☐ Back ☐ Hand ☐ Foot ☐ Elbow/Knee ☐ Other: _____

Substitution for this device is NOT ALLOWED without my written approval

Bracing (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Zynex Pro 637 Lumbosacral Orthosis
☐ Zynex Pro 627 Lumbosacral Orthosis
☐ Zynex Pro 456 Thoracic-Lumbosacral Orthosis
☐ Aspen Horizon 637 Lumbosacral Orthosis
☐ Zynex Pro OA Knee
☐ Zynex Pro Post-Op Knee
☐ Zynex Pro Wrist

DX Code(s) _____.____ _____.____

Knee: ☐ Left ☐ Right

Please document in patient's chart the reason(s) for prescribing and fax with Rx

Cervical Traction (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Cervical Traction (Purchase Only) (Saunders or ComforTrac)

DX Code(s) _____.____ _____.____

Hot/Cold Therapy (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Zynex CryoHeat circulating pump & therapy blanket

Length of Need: ☐15 Days ☐30 Days ☐45 Days ☐Other ___Days

DX Code(s) _____.____ _____.____

I have reviewed the hot/cold therapy contraindications on the back of this prescription prior to prescribing for patient.

Clinic Address | City | St. | Zip

Phone | Fax

Prescriber's Signature* | Date*

Printed Name* | NPI*

☐ _____

If this device was requested by another medical provider, please include their name/address/zip here

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's well-being; 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*.

Fax Rx To: +1 (800) 495-6695 **ORDERS@ZYNEX.COM**