Rx Prescription & Letter of Medical Necessity

Prescriber's Printed Name* _____ NPI* _____

Clinic Address _____ City _____ St. _____ Zip _____

Phone _____ Fax _____

☐ _____

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

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: ☐ Lifetime of Treatment ☐ 3-18 Months

(if unchecked = Lifetime of Treatment)

☐  Zynex M-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 Hybrid Lumbosacral Orthosis
☐ Zynex Pro Low-Profile Lumbosacral Orthosis
☐ Zynex Pro Lumbosacral Orthosis
☐ Zynex Pro Thoracic-Lumbosacral Orthosis
☐ Zynex Pro Wrist
☐ Zynex Pro Post-Op Knee
☐ Zynex Pro OA Knee with Suspension Wrap

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

☐ Zynex DynaComp cold compression & 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.

Prescriber's Signature* _____ Date* _____

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 **Email: Orders@zynex.com**