ZYNEX MEDICAL

OFCD.V1

DME ORDER FORM

Commercial — Medicare — Medicaid — TRICARE — VA — Uninsured

SECTION 1 — PATIENT & INSURANCE INFORMATION

Patient Name _____ **DOB (MM/DD/YY)** _____/_____/_____ **Gender** _____

Shipping Address _____ **City** _____ **State** _____ **ZIP** _____

Primary Phone Number _____ **Secondary Phone Number** _____

Email _____ **Primary Language, if not English** _____

Primary Insurance _____ **Member ID** _____

☐ *If patient is not insured, check this box*

Secondary Insurance _____ **Member ID** _____

SECTION 2 — CLINICAL REQUIREMENTS & THERAPY SCHEDULE

OA Knee Brace (L1851)

☐ Left ☐ Right

☐ M17.0 - Bilateral knee OA
☐ M17.10 - OA, unspecified knee
☐ M17.11 - OA, right knee
☐ M17.12 - OA, left knee
☐ M17.9 - OA, unspecified
☐ Other Dx - _____
☐ Other Dx - _____

Post-Op Knee Brace (L1833), Thigh Circumference: _____in.

☐ QTY 1 ☐ QTY 2

☐ M17.11 - OA, right knee
☐ M17.12 - OA, left knee
☐ G89.18 - Other acute post-procedural pain
☐ M25.561 - Pain in right knee
☐ M25.562 - Pain in left knee
☐ Other Dx - _____
☐ Other Dx - _____

LSO/Back Brace, Waist Circumference: _____in.

☐ Hybrid (Low-Profile and Standard) (L0650)
☐ Low-Profile Only (L0642)
☐ Standard (L0650)
☐ Thoracic LSO (L0457)

☐ M43.16 - Spondylolisthesis
☐ M47.816 - Lumbar spondylosis
☐ M48.061 - Lumbar spinal stenosis
☐ M54.16 - Lumbar radiculopathy
☐ M54.50 - Low back pain, unspecified
☐ M54.6 - Thoracic back pain
☐ M54.9 - Dorsalgia, unspecified
☐ Other Dx - _____
☐ Other Dx - _____

Hot/Cold/Compression Therapy, Dx Code(s): _____, _____, _____

☐ **CryoHeat* (Hot-E1399/E0217)** ☐ **CryoHeat* (Cold-E1399/E0218)**

**ships with universal blanket + 4 reuseable ice cubes (cold only)*

☐ **DynaComp (E1399)** *treatment area (required):*

☐ Ankle ☐ Back ☐ Hip ☐ Knee ☐ Shoulder

Therapy Schedule: Length of Need: _____month(s) (1-24)

Wrist Brace (L3916), Wrist Circumference: _____in.

☐ QTY 1 ☐ QTY 2

☐ G56.00 - Carpal tunnel syndrome, unspecified
☐ G56.01 - Right wrist
☐ G56.02 - Left wrist
☐ G56.03 - Bilateral wrists
☐ Other Dx(s) - _____

☐ **Cervical Traction (E0849)**

Length of Need: _____months

☐ M47.812 - Cervical spondylosis
☐ M48.02 - Cervical spinal stenosis
☐ M54.12 - Cervical radiculopathy
☐ M54.16 - Radiculopathy, lumbar region
☐ M54.2 - Cervicalgia
☐ Other Dx(s) - _____

☐ **InWave (E0740), Probe Required:**

☐ Small (4" L x 0.75" D) ☐ Large (5.5" L x 1" D)

Length of Need: _____months

Frequency: _____x/day

Duration: _____mins/session

☐ N39.3 - Stress urinary incontinence
☐ N39.41 - Urge urinary incontinence
☐ N39.46 - Mixed urinary incontinence
☐ N62.81 - Muscle weakness
☐ N62.89 - Other specified disorders of muscle
☐ N32.81 - Overactive bladder
☐ Other Dx(s) - _____

SECTION 3 — PRESCRIBER INFORMATION

Name: _____ **License:** _____ **NPI:** _____

Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Phone Number:** _____ **Fax Number:** _____

Prescriber Attestation: *By signing below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient's medical condition and the treatment regimen I have prescribed. The medical records for this patient substantiate the prescribed treatment frequency. The patient/caregiver is able to follow instructions for using an e-stim device and is able to use the ordered items.* ***I certify my patient has no medical contraindications making this therapy inappropriate, e.g., pace-maker****. For Medicare/Insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.*

Prescriber Signature: _____ **Date:** _____

FAX TO: +1 (866) 791-2026 OR EMAIL TO ORDERS@ZYNEX.COM

Required: Please attach medical records and copies of the front & back of all insurance cards with the order.