ZYNEX MEDICAL

OFCE.V1

E-STIM 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

Select at least one modality or check all that apply

☐ **TENS, 4-Lead (E0730)**

☐ Acute Postprocedural Pain (G89.18)
☐ Chronic Postprocedural Pain (G89.28)
☐ Chronic Pain Syndrome (G89.4)
☐ Other: _____

If Chronic Pain:

☐ TENS Trial Conducted (Date Range: ____/____/____ - ____/____/____)
and ☐ **DID** provide significant pain relief and improvement in function
☐ **DID NOT** provide significant pain relief and improvement in function
☐ No Trial Conducted

If Acute Post–Surgical, Date of Surgery: _____/_____/_____

☐ **IFC (E1399)**

Rationale for IFC (required):

_____

_____

☐ **NMES (E0745)**

Body Area	Left	Right
Shoulder	☐ M62.512	☐ M62.511
Upper Arm	☐ M62.522	☐ M62.521
Forearm	☐ M62.532	☐ M62.531
Hand	☐ M62.542	☐ M62.541
Thigh	☐ M62.552	☐ M62.551
Lower Leg	☐ M62.562	☐ M62.561
Ankle/Foot	☐ M65.572	☐ M65.571

Other Single Site (M62.58): _____ (Specify)

Other Diagnosis: _____ (Specify)

Cause of Atrophy:

☐ Casting or Splinting of a Limb
☐ Contracture Due to Scarring of Soft Tissue
☐ ACL Repair/Knee Replacement Leading to Quad Atrophy
☐ Other: _____

Nerve Supply Intact? ☐ Yes ☐ No

SECTION 3 — THERAPY SCHEDULE

Length of Need: _____ month(s) (1-24)

Prescribed Use

Minutes Per Session: _____
Sessions Per Day:
Days Per Week: _____

Replace Electrodes: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

SECTION 4 — SUPPLIES

A. Initial Order includes:

- Lead Wires (1 set)
- AC Adapter (1 unit)
- Batteries (4 each)
- Electrodes (16 - 2" round (4 x 4/pk))

B. Optional Garment(s) (E0731):

Conductive

☐ Elbow ☐ Knee ☐ Sock
☐ Glove, Small (7" x 3")
☐ Glove, Large (8.5" x 3.5")

Non-Conductive

☐ Care Vest: Chest circumference: _____ in.
☐ Back: Waist circumference: _____ in.
☐ Lumbar: Lumbar circumference: _____ in.
☐ Shoulder: Chest circumference: _____ in.
☐ Neck: Neck circumference: _____ in.

Reason the Garment(s) Are Necessary:

_____

_____

_____

_____

SECTION 5 — 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 and back of all insurance cards with the order.