ZYNEX MEDICAL

OFL.V1

LIABILITY ORDER FORM

Workers' Compensation — Auto — Personal Injury

SECTION 1 PATIENT INFORMATION

Patient Name _____ **DOB (MM/DD/YY)** _____/_____/_____ **Gender** _____
Address _____ **City** _____ **State** _____ **ZIP** _____
Primary Phone _____ **Secondary Phone** _____ **Email** _____
Primary Language, if not English _____

SECTION 2 INCIDENT & LIABILITY INFORMATION

Incident Date: _____
Date of Medical Necessity Determination: _____
State of Jurisdiction: _____
Body Part(s) Injured: _____

Is The Patient Represented by an Attorney? ☐ Yes ☐ No
If Yes: Attorney Name: _____
Phone: _____ **Email:** _____

INCIDENT TYPE:

☐ **Worker's Compensation**
Employer Name: _____
WC Carrier Name: _____
WC Claim #: _____
UR Determination: ☐ Approved ☐ Not Approved ☐ Unknown
UR Approval # (if applicable): _____
Adjuster Name: _____
Phone: _____ Email: _____
Nurse Case Manager Name: _____
Phone: _____ Email: _____

☐ **Auto**
Auto Insurance Name: _____
Auto Claim #: _____
Adjuster Name: _____
Phone: _____ Email: _____
MedPay Available? ☐ Yes ☐ No ☐ Unknown
Bodily Injury Limit: _____ ☐ Unknown
PIP Limit: _____ ☐ Unknown
Liability Claim Open? ☐ Yes ☐ No ☐ Unknown

If Worker's Compensation order prescribed in NY, has prior-authorization request (PAR) been submitted?
☐ Yes ☐ No (Order will not process without PAR)

SECTION 3 CLINICAL REQUIREMENTS

E-STIM AND THERAPY SCHEDULE

E-STIM Device, Dx Code(s): _____, _____, _____, _____
☐ **Multi-Modality (TENS, NMES, IFC) (E1399)**
☐ **TENS Only (E0730)** ☐ **NMES Only (E0745)**

Supplies
A. Initial Order includes:
Lead Wires (1 set), AC Adapter (1 unit), Batteries (4 each), and 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.

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

Prescribed Use:
Minutes/Session: _____ Session/Day: _____ Days/Week: _____
Replace Electrodes: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

ADDITIONAL PRODUCTS:

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)

Knee Brace, Dx Code(s): _____, _____, _____, _____
Post-Op Knee Brace (L1833) ☐ QTY 1 ☐ QTY 2
Circumference: _____ in.
OA Knee Brace (L1851) ☐ Left ☐ Right

Wrist Brace, Dx Code(s): _____, _____, _____, _____
Wrist Brace (L3916) ☐ QTY 1 ☐ QTY 2
Circumference: _____ in.

LSO (Lumbar-Sacral Orthosis), Dx Code(s): _____, _____, _____
☐ **Hybrid LSO (Low-Profile and Standard) (L0650)**
☐ **Low-Profile LSO (L0642)**
☐ **Standard LSO (L0650)**
☐ **Thoracic LSO (L0457)**
Waist Circumference: _____ in.

☐ **Cervical Traction (E0849),** Dx Code(s): _____, _____, _____

SECTION 4 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., pacemaker****. 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: Attach all medical records. Auto claims require proof of insurance coverage or declaration to process order.