

**Phone 713.218.7959**

**Fax 866.716.9008**

**PLEASE FAX DEMS SHEET WITH RX**

Patient Name: Phone:

**Physician’s**

**Letter of Medical Necessity**

**and Prescription Form**

Date of Birth: Serial Number:

**ASPEN CONTOUR TLSO**

**L0464-NU**

**ICD-9-CM Code(s):**

**Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_ ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Duration:** □ 6-9 Months x Purchase (99 Months) □ Other \_\_ \_\_ (Months)

Previous Treatment(s) and or Medications used in **Past 3-Months**:

□Prior Surgery □NSAIDs □ Physical Therapy □ Pain Medications □ Injections

□ Ice □ Rest □ Other­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Letter of Medical Necessity**

**Innovative R P Inc has supplied this unit as per the above prescription. I recommend this particular device for home use as part of this patient’s physical therapy treatment.**

**- DO NOT SUBSTITUTE –**

**Physician’s Name:** Phone:

**PLEASE COMPLETE THE FOLLOWING: ESTIM DEVICES A&B, OTHER DEVICES A**

**A Device will be used to treat the following conditions:**

□ Inhibit intractable pain □ increase blood flow□ Break muscle spasms

□ re-educate muscles□ reduce edema from trauma/post-op procedure

□ stimulate muscle contractions□ prevent disuse atrophy □ increase ROM

Other (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B Justification for 4 Leads (2 Channels) versus 2 Leads (1 Channel)**

□ Patient’s pain covers a large area and 4-electrodes are needed to surround or treat throughout the pain area.

□ 4 electrodes are needed to treat two different pain areas.

□ Patient is experiencing a radiating pain pattern; 4 electrodes are needed to utilize an overlapping technique along the pain pattern.

□ 4 electrodes are needed to utilize a crossed or interferential style stimulation pattern.

Patient is using for:

□Acute Post Op Pain □ Chronic Intractable Pain How many months? \_\_\_\_\_

Has the patient had a **30 day trial**? □ Yes □ No