essential control systems

HOME ELECTRICAL STIMULATION UNIT LETTER OF MEDICAL NECESSITY

Instructions

1) This form is for Home Electrical Stimulation Purchases ONLY
2) Have prescribing physician complete and sign this form
3) Send completed Letter of Medical Necessity to your insurance for authorization
4) Call 800-537-3779 with any questions about this form

Please note that incomplete forms will result in delays

Patient Information

Last Name _____ First Name _____ Male or Female (circle one) _____

Address _____

City _____ State _____ Zip _____

( ) _____ ( ) _____

Home Phone Work/Daytime/Mobile Phone

Insurance Policy ID _____ Group# _____ Insurance phone # _____ Date of Birth ___/___/___

Medical Necessity (For Home Electrical Stimulation Units Only)

Has the patient undergone and failed a documented trial of pelvic muscle exercise training prescribed for a duration of 4 weeks? ____**YES** ____**NO**

Are the results of the PME trial documented in the patient's medical notes? ____**YES** ____**NO**

Is the patient cognitively intact? ____**YES** ____**NO**

Please check the patient's diagnosis (one only):

- ☐ N39.41 Urge Incontinence
- ☐ N39.3 Stress Incontinence
- ☐ N39.46 Mixed Incontinence (female) (male)
- ☐ R15.9 Full incontinence of feces
- ☐ _____ Other

Prescribing Physician Name _____ NPI# _____

Prescribing Physician Address _____ Prescribing Physician's Phone Number _____

Prescribing Physician Signature _____ Date _____