



DME ORDER FORM

OFCD.V2

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

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

- QTY 1 QTY 2
- M17.11 - OA, right knee M25.561 - Pain in right knee
 M17.12 - OA, left knee M25.562 - Pain in left knee
 G89.18 - Other acute post-procedural pain 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 M54.6 - Thoracic back pain
 M47.816 - Lumbar spondylosis M54.9 - Dorsalgia, unspecified
 M48.061 - Lumbar spinal stenosis Other Dx - _____
 M54.16 - Lumbar radiculopathy Other Dx - _____
 M54.50 - Low back pain, unspecified

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

- CryoHeat* (Hot-E1399/E0217) CryoHeat* (Cold-E1399/E0218)
 *ships with universal blanket + 4 reusable ice cubes
- 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
 M62.81 - Muscle weakness
 M62.89 - 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.