



E-STIM ORDER FORM

OFCE.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

Select at least one modality or check all that apply

TENS, 4-Lead (E0730) IFC (E1399)
 Acute Postprocedural Pain (G89.18) **Rationale for IFC (required):**
 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: ____/____/____

NMES (E0745)

Body Area	Left	Right
Shoulder	<input type="checkbox"/> M62.512	<input type="checkbox"/> M62.511
Upper Arm	<input type="checkbox"/> M62.522	<input type="checkbox"/> M62.521
Forearm	<input type="checkbox"/> M62.532	<input type="checkbox"/> M62.531
Hand	<input type="checkbox"/> M62.542	<input type="checkbox"/> M62.541
Thigh	<input type="checkbox"/> M62.552	<input type="checkbox"/> M62.551
Lower Leg	<input type="checkbox"/> M62.562	<input type="checkbox"/> M62.561
Ankle/Foot	<input type="checkbox"/> M62.572	<input type="checkbox"/> M62.571

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.