



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: _____ Is The Patient Represented by an Attorney? Yes No
 State of Jurisdiction: _____ If Yes: Attorney Name: _____
 Body Part(s) Injured: _____ 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 for E-Stim or Hot/Cold Therapy, 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

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.