StimRouter®
Neuromodulation System

BIONESS STIMROUTER® NEUROMODULATION SYSTEM PHYSICIAN STATEMENT OF MEDICAL NECESSITY/ PRESCRIPTION (FORM II)

ALL SECTIONS MUST BE FILLED OUT COMPLETELY

Patient Legal Name: First	MI.	Last	
Street Address:	City:	State:	Zip:
Patient DOB: MM/DD/YYYY	Phone:		

Initial Order Date:	Revised Order Date:	Renewal Order Date:

☐ StimRouter Neuromodulation System & Supplies (Disposable Electrode Patch changed every 2 to 3 days)

☐ Pain Duration documented as existing longer than 3-months

Primary Diagnosis (mark all that apply):

Pain ______________ (ICD-10 code) Pain, not classified ______________ (ICD-10 code) Other ______________ (ICD-10 code)

Location: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand/Fingers ☐ Unspecified
☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Leg/Thigh

Functional Limitations:

Patient's need (mark all that apply):

☐ Pain Reduction, localized
☐ Improve Functional Capabilities
☐ Reduce dependency on oral medications
☐ Other (explain)

Length of Need:	Prognosis:

PHYSICIAN INFORMATION

Physician:	License #:	NPI #:
Address:	Phone:	Fax:
City, State, Zip:	Office Contact:	
Physician's Signature:	Date:	

State law requires renewal on said item every 12 months. Length of need is dictated based on state standard of 1 year unless indicated above. I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary for this patient's treatment.

Upon completion, fax this form to Bioness Client Relations Department
Fax: 661.310.9623 | Phone: 800.211.9136 option 2

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