

**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:
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<input type="checkbox"/> StimRouter Neuromodulation System & Supplies (Disposable Electrode Patch changed every 2 to 3 days)
<input type="checkbox"/> 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: <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Unspecified <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle/Foot <input type="checkbox"/> Leg/Thigh
Functional Limitations:  
Patient's need (mark all that apply): <input type="checkbox"/> Pain Reduction, localized <input type="checkbox"/> Improve Functional Capabilities <input type="checkbox"/> Reduce dependency on oral medications <input type="checkbox"/> Other (explain)
Length of Need:    Prognosis:

PHYSICIAN INFORMATION		
Physician:	License #:	NPI #:
Address:	Phone:	Fax:
City, State, Zip:	Office Contact:	
Physician's Signature:	Date:	
<i>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.</i>		

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