ReVive Systems
700 N Santa Fe Ave
Edmond, OK 73003
Phone: 877-573-8378
Fax: 800-397-5143

Order Date: ____________________________

Patient's Name: ____ Date of Birth: ___________________________

Patient's Address: ____

City: ________________________ State: _________ Zip: __________ Patient's Phone: _______________________________

WRITTEN ORDER

I certify that the equipment listed below is medically necessary as part of the conservative care plan for this patient.

ELECTROTHERAPY:

_____ TENS Unit (4 LEAD TENS UNIT) Estimated Length of Need (Months): _____________ 1-99 (99 = Lifetime)

_____ NMS Estimated Length of Need (Months): _____________ 1-99 (99 = Lifetime)

RECOMMENDED USAGE: ______ / day for_____ minutes

ELECTRODE REPLACEMENT: 1 2 3 4 5 6 7 8 9 10 11 12 (MONTHS)

Generally, insurance will cover one package per month as long as the unit has been purchased.

COVERAGE FOR ACUTE POST-OPERATIVE PAIN:

The following must be noted in the medical record:

The date of the surgery:________________________________ The nature of the surgery:_____________________________

Location of the pain:___________________________________ Severity of the pain:__________________________________

COVERAGE FOR CHRONIC PAIN:

The following must be noted in the medical record:

Location of the pain:___________________________________ Severity of the pain:__________________________________

Duration of time the patient has had the pain:_____________ Presumed etiology of the pain:_________________________

Prior treatments tried and results:____

____

RE-EVALUATIONS AT THE END OF THE TRIAL PERIOD MUST INCLUDE:

The following must be noted in the medical record:

How often the patient has been using the TENS:______________________/ DAY_________

Typical length of each treatment and the results:____________________________________

ICD-10 CM Code(s)

___ G89.4 Chronic Pain Syndrome
___ G56.00 Carpal Tunnel Syndrome
___ G60.9 Peripheral Neuropathy
___ M15.0 Degenerative Joint Disease
___ M17.10 OA of the Knee
___ M23.50 Ligament Tear
___ M54.2 Cervicalgia
___ M79.1 Myalgia Myositis
___ M79.609 Limb Pain
___ M62.40 Muscle Spasm
___ M62.81 Muscle Weakness
___ S83.8X9A Knee Sprain
___ Other __________________

Yes	No	
☑	____	Does this equipment improve patient's functional mobility?
☑	____	This equipment is needed for an indefinite period of time (purchase)?

Physician's Name: ____ NPI #: ______________________________________

Physician's Signature: ____ Date: __________________________

Signature Required – No Stamps

Order Start Date: ___________________________ Received Date: _________________________