CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A: Consumer/Provider Information

Certification Type ☐ Initial ☐ Revised ☐ Recertification			
Consumer's Name		Provider's Name	
Consumer DOB	Consumer Sex ☐ Female ☐ Male	Consumer HT (in.)	Consumer WT (lbs.)
(If consumer is not residing at home address) Facility Name		Prescriber's Name	
		Prescriber's NPI Number	
Facility Address		Prescriber's Telephone	
Facility City, State and Zip Code		Prescriber's Medicaid Legacy Number	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months) 1 - 99 (99 = LIFETIME)	Diagnosis Codes (ICD-9) and Descriptions
Last Consumer Medical Examination (MM/DD/YR)	

ANSWERS	ANSWER QUESTIONS 1-9 FOR RENTAL OF TENS UNIT, AND 3-12 FOR PURCHASE OF TENS UNIT. (Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
☐Y ☐N ☐D	1. Does the consumer have acute post-operative pain?
	2. What is the date of surgery resulting in acute post-operative pain?
☐Y ☐N ☐D	3. Does the consumer have chronic, intractable pain?
[months]	4. How long has the consumer had intractable pain? (Enter number of months, 1 - 99)
☐1 ☐2 ☐3 ☐4 ☐5	5. Is the TENS unit being prescribed for any of the following conditions? (Check the appropriate number) 1- Headache; 2 - Visceral abdominal pain; 3 - Pelvic pain; 4 -Temporomandibular joint (TMJ) pain; 5 - None of the above
☐Y ☐N ☐D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
☐Y ☐N ☐D	7. Has the consumer received a TENS unit trial?
Begin/Ended	8. What are the dates that the trial of TENS unit began and ended?
	9. What is the date you reevaluated the consumer at the end of the trial period?
☐1 ☐2 ☐3	10. How often has the consumer been using the TENS unit? (Check the appropriate number) 1 = Daily; 2 = 3 to 6 days per week; 3 = 2 or less days per week
☐Y ☐N ☐D	11. Do you and the consumer agree that there has been a significant improvement in the pain and the long term use of a TENS unit is warranted?
☐2 ☐4	12. Number of TENS unit leads (i.e., separate electrodes) routinely needed and used by the consumer at any one time. (Check appropriate number) 2 = 2 leads 4 = 4 leads

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print)

Name	Title	Employer

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for <u>each</u> item, accessory, and option.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature	Date

ODM 03402 (7/2014)
Formerly JFS 03402 (Rev. 10/2008)