Office: 336-602-1668 Fax: 866-211-2286

2255 Lewisville Clemmons Rd.
Suite F
Clemmons, NC 27012

Patient Name: ______________________________ Date of Order: _____________

Patient Phone Number: (____) _______________ Date of Birth: ______________

Diagnosis(s): ____

ICD10 Code(s): ____

☐ **E0118 – Knee Scooter** **LENGTH OF NEED: _______________**	☐ **L3670 – Shoulder Orthosis**
☐ **E0143 – Walker (no wheels)**	☐ **E0936 – Shoulder CPM**
☐ **E0143 – Walker w/ 2 wheels on front**	☐ **E0935 – Knee CPM**
☐ **E0143/E0156 – Rollator w/ seat**	☐ **Oxygen Concentrator**

☐ **E0730 – TENS – Four Lead** (Nerve Stimulator) **Length of Need: ____ months**

☐ **E0720 – TENS – Two Lead** (Nerve Stimulator)

- ☐ A4557 LEAD WIRES – 1 PAIR/YEAR - FREQUENCY OF CHANGE: YEARLY
- ☐ A4595 TENS SUPPLIES – 2 UNITS/MONTH - FREQUENCY OF CHANGE: EVERY 15 DAYS

☐ **E0731 – Conductive Garment – please indicate type needed** ________________________

☐ **Other:** ____

Start Date: _____/_____/________ (ONLY IF DIFFERENT FROM THE ORDER DATE)

I certify that the items listed above are medically necessary for the treatment of the patient for the above condition.

Physician Name (Print):____________________________ Phone #: (____) ___________

Physician Signature: ____________________________ Date: _____ /_____ /________

Physician NPI: ________________________________

Fax this form to 866-211-2286 with the following: 1. Clinical notes with diagnosis 2. Patient demographics 3. Copy of patient insurance card

Visit us at www.piedmontmedicalsolutions.com