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Physician's Prescription—Statement of Medical Necessity

Name of Patient: _____

Address: _____

Home Phone: _____

Work Phone: _____

Diagnosis Codes:

Reason for Equipment:

Reduction of Pain	Increase Functional Mobility
Decrease Edema & Inflammation	Reduce Muscle Spasms
Stimulate Soft Tissue Healing	Increase Range of Motion

The above identified equipment is medically necessary for an estimated period of time indicated below:

3 Month _____ 6 months or less _____ 12 months or more _____ Purchase _____

PRESCRIPTION

STIMULATION

TENS Unit Muscle Stim Microcurrent Interferential Unit Combo Unit Four Channel Unit

CERVICAL TRACTION _____

LUMBAR TRACTION: _____

BRACE OR OTHER PRODUCTS: _____

BRACE/OTHER DISCRPTION: _____

STIMULATOR/TRACTION/BRACES/OTHER: _____

Name of Physician _____

Address _____

City/State/Zip _____

Phone Number _____

I the undersigned certify that the above equipment is medically necessary for this patient's being. In my opinion the equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment. of this patient's condition and is NOT prescribed as "CONVENIENCE" equipment.

PHYSICIAN'S SIGNATURE

DATE AUTHORIZED