

**Alpha-Stim PPM
Certificate of Medical Necessity**

I. Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____ DOB: _____

SSN: _____ Ht: _____ Weight: _____

II. Medical Necessity

Complete Diagnosis: 1) _____ ICD-9 Code: _____

2) _____ ICD-9 Code: _____

3) _____ ICD-9 Code: _____

Prognosis:

Medically Necessary for:

Estimated Length of Need:	Months	Years
Life _____	1 2 3 4 5 6 7 8 9 10 11	1 2 3 4 5 6 7 8 9 10

Please list all other less costly methods used and why the have not met the patient's needs:

- 1) _____
- 2) _____
- 3) _____

Has the patient tried the Alpha Stim PPM Unit in therapy? Y N (Please Explain)

What supplies will the patient need with the Alpha Stim PPM unit?

Electrodes, 1/5". 4/pk 48" lead wires

III. Prescribing Physician & Clinic Information: (Please Print)

Name: _____ Street Address: _____

UPIN #: _____ License #: _____ Medicaid #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Physician Signature: _____ Date: _____