

ALPHA-STIM SCS - STRESS CONTROL SYSTEM

Certificate of Medical Necessity

Patient: _____ Date: _____, 200__

SS#: _____ DOB: _____

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

Phone: _____

Contraindications for use: Pregnancy Pacemaker Does the patient have either? Yes No

Diagnosis (ICD 9 Code): E 1399

Patient Complaints _____

Discomfort Level: 1 2 3 4 5 6 7 8 9 10

Prognosis: Good Fair Poor

Anxiety Level: 1 2 3 4 5 6 7 8 9 10

Depression Level: 1 2 3 4 5 6 7 8 9 10

Date of Symptom Onset: _____ Date Last Consulted: _____

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

Has this patient received previous treatments:

Results

1. Medications: Yes No _____

2. Alternative Therapy: Yes No _____

3. Other: _____

Has the patient had diagnostic testing? Yes No Type: _____

Therapeutic Goals: Symptom Relief Medication Reduction Improved Function

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

I am ordering the purchase of an Alpha-Stim[®] prescription electromedical device complete with accessories for the above named patient to use at home as a conservative method of treating pain, anxiety, depression and/or insomnia. This technology has a 25-year history and is supported by successful outcomes documented by more than 40 scientific studies (see www.alpha-stim.com for annotated abstracts). The Alpha-Stim SCS is cleared by the FDA for treating stress, anxiety, depression and insomnia. It has shown to be consistently effective so I have advised the patient to utilize it on a regular basis.

I want this patient to have the Alpha-Stim[®] SCS cranial electrotherapy stimulator for the treatment of anxiety, depression, and/or insomnia. (*Do not substitute*):

Doctor's Signature: _____ Date: _____

Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

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