DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Seminar Notes www.neuropathydr.com

Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DME 06.03B

CMS-848 — TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
Patient Name Patient Address City, State, Zip (877) 585 - 8230 HICN 123-45-6789	ReBuilder Medical Technologies,Inc 636 Treeline Drive, Charles Town, WV 25414 (877) 585 - 8230 NSC or NPI # 1245489822

PLACE OF SERVICE	HCPCS CODE	PT DOB / Sex / Ht. / Wt
Home (12)	E0720	04 / 01 / 45 Sex M (M/F) Ht. 65 (in) Wt 170 (lbs.)

NAME and ADDRESS of FACILITY *if applicable (see reverse)*	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN
	Dr. E. Doctor 767 Nadenbouch Lane Charles Town, WV 2541 (301)555 - 1212 UPIN or NPI # 1234567890

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS) 1–99 *(99=LIFETIME)* DIAGNOSIS CODES (ICD-9): _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-6 for purchase of TENS (Circle Y for Yes, N for No,)
(Y) N	1. Does the patient have chronic, intractable pain?
(12) Months	2. How long has the patient had intractable pain? (Enter number of months, 1–99.)
1 2 3 4 (5)	3. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above
(Y) N	4. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
(Y) N	5. Has the patient received a TENS trial of at least 30 days?
(__/__/____)	6. What is the date that you reevaluated the patient at the end of the trial period? 30-60 Days After Section Prescription Date.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

To Be Completed by Supplier

SECTION D **PHYSICIAN Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

Signature and Date Stamps Are Not Acceptable.

SAMPLE

Form CMS-848 (09/05)

This SAMPLE is solely for educational purposes and not intended to influence the physician's clinical judgement or practice