

## Patient Information

Patient Name:	Shipping Address:
DOB:	City/State/Zip:
Diagnosis:	Patient Cell:
ICD-10 Code(s):	Patient Email:
Insurance ID #:	Secondary Insurance ID #:
Insurance Group #:	Secondary Insurance Group #:

## Adjustor Information (for workers' compensation only)

Claim #:	Adjuster Name:
DOI:	Adjuster Phone:

## Physician's Letter of Medical Necessity (LMN)

This letter is to request benefits of the FDA cleared BioWave® Neurostimulation Pain Therapy System for the said patient. Due to the patient's condition, BioWave® treatment is required to decrease pain, reduce opioid consumption and accelerate return to function. BioWave® uses a patented electronic signal technology allowing delivery of the electrical signals directly to the surface of pain nerves which prevents the formation of the pain signal and blocks the transmission of chronic, acute and post-surgical musculoskeletal pain. Based on the patient's condition and medical need, our current treatment plan includes use of the BioWave® system.

### RX For Neurostimulator

### RX For Electrodes (Please choose one)

**BioWaveHOME Neurostimulation Pain Therapy System**  
(HCPC CODE: E1399)

**B-Set Electrodes, Non-Invasive**  
(HCPC CODE: A4595)

**B-Set Electrodes, Percutaneous**  
(compatible with BioWaveHome ONLY)  
(HCPC CODE: A4595)

### RX For Back BioWrap

### RX For Migraine BioWrap

(compatible with BioWaveHOME ONLY (HCPC CODE: E0731))

**Back BioWrap Extender** (HCPC CODE: A9900)

(HCPC CODE: E0731)

**S/M Waist 28"-37"**  **L/XL Waist 38"-50"**

**Provides extra 10", Waist size 51" - 60"**

**OS** Circumference Around Neck 12" - 20"

### RX For Knee BioWrap (HCPC CODE: E0731)

### RX For Foot-Ankle BioWrap (HCPC CODE: E0731)

**S/M** Circumference Around Kneecap: 12"-15.5"  **L/XL** Circumference Around Kneecap: 15.5"-19"

**S/M** Shoe Size: Men: 5-9, Women: 6-10

**L/XL** Shoe Size: Men: 10-15, Women: 11-16

### RX For Hand-Wrist BioWrap (HCPC CODE: E0731)

### RX For Thigh-Calf BioWrap

**S/M** Wrist Circumference 5.75"-7"  **L/XL** Wrist Circumference 7"-8.5"

**OS** Min Circumference 12" Max Circumference 30"

## PLEASE CHECK BOXES THAT APPLY:

### Length of Need:

**99 Months (Lifetime)**  **6-9 months**  **3-6 months**

### Frequency of Use:

**1X Day**  **2X Day**  **3X Day**  **Other** \_\_\_\_\_

### Prescriber Information

Physician Name:	NPI #:
Address:	Tax ID #:
Phone:	Date:
Fax/Email:	Physician Signature:

### Credit Card Information

Cardholder Name	Card Number
Expiration Date MM/YY	CVV
	Billing Address

**Chart Notes and RX must be submitted together. Include chart notes supporting Medical Necessity (clinical documentation must support the continued need, use, and benefit that the device provides).**

## BIOWAVE ACCOUNT EXECUTIVE NAME: