



MEDICAL SUPPLY

Voice: 1-800-657-4090

Fax: 1-866-626-7881

Rx TENS UNITS for trial period E0730RR

Patient's Name: _____

HIC#: _____

Address: _____

DOB: _____

Insurance Name: _____

Insurance Phone: _____

Phone: _____

Patient would benefit from the use of **Transcutaneous Electrical Nerve Stimulation** because of:

Please mention the medical condition here:

Diagnosis Code(s): _____, _____, _____, _____

Physician's Signature: _____ Date signed: ____/____/____

Physician Name: _____ NPI: _____

Address: _____

Physician Phone: _____ Fax: _____