BIONESS FUNCTIONAL NEUROMUSCULAR STIMULATOR PRESCRIPTION & LETTER OF MEDICAL NECESSITY

bioness®
A Bioventus Rehab Company

ALL SECTIONS MUST BE FILLED OUT COMPLETELY BY QUALIFIED PHYSICIANS

Patient Legal Name: First	MI.	Last	
Street Address:	City:	State:	Zip:
DOB: MM/DD/YYYY	Phone:		
Email:	Mobile Phone:		

Initial Order Date:	Revised Order Date:	Renewal Order Date:

L360 Thigh System, L300® Go Thigh Stand-Alone System & Supplies* for: ☐ Neuromuscular Electrical Stimulation (NMES) ☐ Functional Electrical Stimulation (FES)

Primary ICD-10 Diagnosis (mark all that apply):

Muscle Weakness/Atrophy, right Thigh _____ ICD-10 code

Muscle Weakness/Atrophy, left Thigh _____ ICD-10 code

CVA _____ ICD-10 code/ICD-9 code

Multiple sclerosis _____ ICD-10 code/ICD-9 code

Spinal cord injury _____ ICD-10 code/ICD-9 code

Traumatic brain injury _____ ICD-10 code/ICD-9 code

Other _____ Describe _____ ICD-10 code/ICD-9 code

Other _____ Describe _____ ICD-10 code/ICD-9 code

Foot Drop _____ ICD-10 code/ICD-9 code

Hemiplegia/Hemiparesis _____ ICD-10 code/ICD-9 code

Secondary ICD-10 Diagnosis (mark all that apply):

(Device is used for muscle strengthening and prevention and retardation of disuse atrophy, not indicated for alleviation of pain associated with the following conditions)

Osteoarthritis (OA) _____ ICD-10 code

Meniscus Tear _____ ICD-10 code

Total Hip Arthroplasty (THA) _____ ICD-10 code

Total Knee Arthroplasty (TKA) _____ ICD-10 code

Patella Femoral Pain Syndrome (PFPS) _____ ICD-10 code

Knee Ligament Injury (ie. ACL, PCL, MCL, LCL) _____ ICD-10 code(s)

Other _____ Describe _____ ICD-10 code

Other _____ Describe _____ ICD-10 code

Affected Side: ☐ Right ☐ Left ☐ Both

PHYSICIAN INFORMATION

Physician:	License #:	NPI #:
Address:	Phone:	Fax:
City, State, Zip:	Office Contact:	
Physician's Email Address:		
Physician's Signature:	Date:	

State law requires renewal on said item every 12 months. Length of need is dictated based on state standard of 1 year unless indicated above. I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary for this patient's treatment.

Upon completion, email this form to Bioness Client Relations Department at: cmafaxes@bioness.com or fax to: 877-362-4855 | Contact Phone: 800-211-9136 option 2

*Electrodes are to be changed at least every 2 weeks per manufacturer's recommendation.

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Innovations For Active Healing

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