BIONESS FUNCTIONAL NEUROMUSCULAR STIMULATOR
PHYSICIAN STATEMENT OF MEDICAL NECESSITY/PRESCRIPTION (FORM II)

ALL SECTIONS MUST BE FILLED OUT COMPLETELY

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

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

☐ L300 Go™/L300® Foot Drop System & Supplies*	☐ L300 Go™ Thigh Plus, Thigh Stand-Alone/ L300® Plus System Full, Upgrade, & Supplies*	☐ H200® Wireless Hand Rehabilitation System & Supplies*

* Changed at least every 2 weeks per manufacturer's recommendation.

Primary Diagnosis (mark all that apply):

CVA _____ ICD-10 code Multiple sclerosis _____ ICD-10 code Spinal cord injury _____ ICD-10 code

Traumatic brain injury _____ ICD-10 code Other _____ Describe _____ ICD-10 code Other _____ Describe _____ ICD-10 code

Foot Drop _____ ICD-10 code	Hemiplegia/Hemiparesis _____ ICD-10 code
Other _____ Describe _____ ICD-10 code	Other _____ Describe _____ ICD-10 code
Affected Side: ☐ Right ☐ Left ☐ Both	Date of Incident/Year of Diagnosis:

Functional Limitations:

Patient's need (mark all that apply):

☐ Facilitate muscle reeducation	☐ Increase local blood circulation
☐ Prevent/retard disuse atrophy	☐ Stimulate muscles that dorsiflex the foot to improve gait
☐ Increase joint range of motion	☐ Other (explain)

Length of Need:	Prognosis:

PHYSICIAN INFORMATION

Physician:	License #:	NPI #:
Address:	Phone:	Fax:
City, State, Zip:	Office Contact:	
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, fax this form to Bioness Client Relations Department
Fax: 877.362.4855 | Phone: 800.211.9136 option 2

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