



Statement of Medical Necessity for Alpha-Stim® Purchase

ALL HIGHLIGHTED FIELDS ARE REQUIRED TO DISPENSE AN ALPHA-STIM DEVICE

As a Licensed Health Care Practitioner, I am providing this document and completing the information below to serve as a prescription for the Alpha-Stim device, complete with accessories, for the patient identified on this form, to use at home as a conservative method of treatment.

DEVICE SELECTION

I am ordering this patient to have the following Alpha-Stim device to use as directed: *(please choose)*

- Alpha-Stim M - microcurrent stimulator for the control of pain, anxiety, and/or insomnia.
- Alpha-Stim AID - cranial electrotherapy stimulator for the treatment of anxiety and/or insomnia.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Responsible Party (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DIAGNOSIS CODES (ICD-10)

The patient's current diagnosis(es) applicable to Alpha-Stim treatments is (are):

_____ ICD 10 Code: _____ ICD 10 Code: _____
 _____ ICD 10 Code: _____ ICD 10 Code: _____

HEALTH CARE PRACTITIONER INFORMATION

Practitioner Name: _____ Degree/Title: _____

NPI: _____ State License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

I certify that I am the Health Care Practitioner identified in this form and I am licensed in my state to use or order the use of an Alpha-Stim medical device. I certify that the statement of medical necessity information on this form is true, accurate, and complete, to the best of my knowledge.

Signature: _____ Date: _____ *(Rx valid for one year from the date on this form)*

Please fax or email completed form to: (940) 328-0888 or info@epii.com