Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for TENS unit

Date: ____/_____/_______ **Requesting Provider:** ______________________________

Pt. Name: _________________________________ **I.D. Number:** ____________________

	Y	N	D
1. Does the patient have acute post-operative pain?	Y	N	D
2. What was the date of surgery resulting in acute post-operative pain?			
3. Does the patient have chronic, intractable pain? If yes, please describe the type or cause of the chronic, intractable pain:	Y	N	D
4. How long has the patient had intractable pain? (indicate number of months)			
5. What other treatment(s) have been tried and failed?			
6. Estimated length of need (in months): ___________________________ (99=forever)			

Additional Clinical Rationale (Print):

Contact Name: ________________________________ **Phone :**________________

______________________________________ ______________________________

Physician Signature **(Stamps are not acceptable)** **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:
1. Typed office note with pertinent information.

Rev. 06/28/2011