Medical Management & Policy

Wedieur Wamagement & Foney			
Fax Number:	412-544-2921		

Certificate of Medical Necessity (CMN) for TENS unit			
Date:/ Requesting	Provider:		
Pt. Name:	I.D. Number:		
1. Does the patient have acute post-operative pain?	Y	N	D
2. What was the date of surgery resulting in acute pos	st-operative pain?		
3. Does the patient have chronic, intractable pain?	Y	N	D
If yes, please describe the type or cause of the chronic, intractable pain:			
4. How long has the patient had intractable pain? (ind	licate number of months)		
5. What other treatment(s) have been tried and failed?			
	/00-C		
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 info	ormation.	