Medical Management & Policy
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 post-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? (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.