PHYSICIAN'S WRITTEN ORDER FOR REPLACEMENT EXTERNAL DEVICE FOR THE BOSTON SCIENTIFIC SPINAL CORD STIMULATOR IMPLANTATION

Fax or email this form to SunMed Medical
FAX # 800-715-5422 | **Phone**# 833-407-1008
Email : BSCOrders@sunmedmedical.com
www.SunMEDChoice.com

Rx This form is a Prescription and Attestation of Medical Necessity and must be added to the patient's Medical Record. All fields are required for insurance approval.

PATIENT INFORMATION

Patient First Name: Please Print	Patient Last Name: Please Print	
Date of Birth:	Mobile Phone:	Alternate Phone:
Address:		Suite / Unit:
City:	State:	ZIP Code:
E-Mail:		

The surgically implanted device requires the external charger/programmer to function. My patient's current device is non-functioning and must be replaced. It is no longer under the manufacturer's warranty.

Date of Implantation: _____ **Date of one year warranty expiration:** _____

Check as applicable:

Product

- ☐ Precision Charging System – HCPCS Code L8689 — Quantity: 1
- ☐ Precision Patient Programmer Kit – HCPCS Code L8681 — Quantity: 1
- ☐ Freelink Remote Control Kit – HCPCS Code L8681 ☐ Alpha ☐ Spectra — Quantity: 1

PRESCRIBER INFORMATION

Prescriber First Name: Please Print	Prescriber Last Name: Please Print	
Office Contact/Transmitting Personnel:	NPI #:	
Address:		Suite / Unit:
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Provide ICD-10 diagnosis code & description: _____

Length of need (months), 99 = lifetime: _____

IMPORTANT: Patient chart notes must be submitted that show medical necessity for the devices ordered to understand why their current device is not meeting their medical need.

I certify that I am the physician identified on this form. I have reviewed this Physician's Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product listed, and the physician notes and other supporting documentation will be provided upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature Required: _____ Date: _____

Stamps are not acceptable