PHYSICIAN'S WRITTEN ORDER

Fax or email this form to SunMed Medical
FAX # 800-715-5422 | **Phone**# 833-936-3336
Email : Medtronic@sunmedmedical.com
www.SunMEDChoice

Rx This form is a Prescription and Statement of Medical Necessity. 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:		

Check one (1) as applicable:

HCPCs *Product*

☐ L8681 **Sacral Nerve Stimulation (SNS): Provide implant date: _____**
- ☐ TH90Q01 InterStim™ patient programmer — Quantity: 1

☐ L8681 **Spinal Cord Stimulation (SCS): Provide implant date: _____**

Model number if known :
- ☐ 97740 MyStim™ Patient Programmer — Quantity: 1
- ☐ 97745 Intellis™ Patient Programmer — Quantity: 1
- ☐ TH91SCSVUS Vanta™ PC MyStim™ PC Smart Patient Programmer — Quantity: 1

☐ A9900 **Targeted Drug Delivery (TDD): Provide implant date: _____**
- ☐ TH90T01 myPTM™ Personal Therapy Manager — Quantity: 1

☐ L8681 **Deep Brain Stimulation (DBS): Provide implant date: _____**

Model number if known :
- ☐ 37441 Intercept™ Patient Programmer — Quantity: 1
- ☐ TH90D01 Activa™ Patient Programmer — Quantity: 1
- ☐ TH91D01 Percept™ Patient Programmer — 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 Diagnosis (Include ICD-10 code & description): _____

_____

Length of need: 99 **months** *(99 means 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