APPENDIX L

CERTIFICATION FOR TENS UNIT

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member's Name____

Member's Medicaid Number ____________________ DOB____________

Related Diagnoses:____

1. Does the patient have acute post-operative pain? **Y N D**
2. What is 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 of chronic, intractable pain?

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______

4. How long has the patient had intractable pain? (Enter number of months) ______________
5. What other treatment modalities have been tried and failed?

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____

Estimated Length of Need (in months): ______

Clinical Rationale____
____
____

Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 –Headache; 2 - Visceral abdominal pain; 3 - Pelvic pain; 4 -Temporomandibular joint (TMJ) pain ; 5 – chronic low back pain/lumbar pain/lumbago; 6 – none of the above

Contact Name:________________ **Phone Number:** ____________

________________ ____/____/____
Physician Signature Date
(Stamps are not acceptable)