DOB: _____

MDCR#: _____

Patient Information:

Name: _____

Phone: _____

ATTENDING PHYSICIAN'S INSTRUCTIONS

1. Please provide appropriate answers for **STATEMENTS 1 and 2**.
2. Please **SIGN and DATE (ORIGINALS ONLY)** and provide the requested information.
3. Fax this completed form to the above fax number.

Statement of Certifying Physician & Prescription for: **J STIM (E0762)**

Patient requires the Jstim therapy system - this modality provides a proprietary electrotherapy signal that is safe and effective to treat Osteoarthritis or Rheumatoid Arthritis of the knee or Hand.

The Jstim Joint therapy system provides a therapeutic benefit that is intended to treat Osteoarthritis and/or Rheumatoid Arthritis. Through form fitting compression wraps, the patient can sleep with the system around the knee or hand for long term treatments

1. **Please specify body part needing therapy:**
   - ☐ Hand
   - ☐ Knee

2. **Please provide an appropriate diagnosis:**
   - ☐ 714.0 – 714.4 Rheumatoid arthritis
   - ☐ 715.16 Osteoarthritis Localized primary involving lower leg
   - ☐ 715.26 Osteoarthritis localized secondary involving lower leg
   - ☐ 715.36 Osteoarthritis unspecified whether generalized or localized involving lower leg.
   - ☐ 715.96 Osteoarthritis of the lower leg
   - ☐ 715.94 Osteoarthritis of the hand

3. **Therapeutic use is for: Osteoarthritis (hand or knee) and Rheumatoid Arthritis (hand or knee)**
   Estimated Length of need (# of months): _____ 1-99 (99=lifetime)
   The Jstim is recommended to be used for 7 hours per day; for a cumulative treatment time of 1200-1500 hours.

4. **Please provide chart notes which mention the need of the Jstim therapy system.**
   The patient is under a comprehensive plan of care for their condition(s).
   The above equipment is medically necessary because of their condition(s).

ATTENDING PHYSICIAN SIGNATURE ONLY – NO RESIDENTS OR NURSE PRACTITIONERS

SIGN **DATE**

PHYSICIAN'S SIGNATURE:_____ Date: _____ / _____ / _____

Original Signature and Date Only – NO STAMPS

PHYSICIAN NAME: _____ UPIN# _____ NPI#: _____

Address _____ Phone: (_____) _____ - _____

City _____ State _____ ZIP _____ Fax: (_____) _____ - _____

Physician agrees to keep chart notes about the requested equipment and the patient's condition, and will forward to _____ upon request.