Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment – TENS Unit Precertification Review

Date: ________________ Reference #: _____________________________(provided after initial review)

A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Facility Information

Facility Name: ____

Address: ____

Phone: ____________________________

Fax: ____________________________

Patient Information

Patient Name: ____

ID Number: ____________________________

Patient DOB: ____________________________

Address: ____

Phone: ____________________________

Physician Information

Ordering Physician Name: ____

Address: ____

Phone: ____________________________

Fax: ____________________________

TIN: ____________________________

Treatment Information

Pertinent Medical History (submit history, physical and include previous treatments and dates): __________________

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Start Date: ____________________________

Anticipated Length of Use: ____________________

Diagnosis (ICD-10) Code: ____________________

DME (HCPC/CPT) Code: ____________________

Current Signs/Symptoms: ____

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Does this patient have history of trauma? ☐ YES ☐ NO

Does patient complain of musculoskeletal pain? ☐ YES ☐ NO

If yes, please describe: ____

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Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Was conservative management tried? ☐ YES ☐ NO

If yes, please describe: ____

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Is this initial rental? ☐ YES ☐ NO

Is this re-certification? ☐ YES ☐ NO

Does the patient use the TENS unit? ☐ YES ☐ NO

Does the patient get relief from the TENS unit? ☐ YES ☐ NO

Does the TENS allow for decreased pain medications? ☐ YES ☐ NO

Does the TENS allow for increased activity? ☐ YES ☐ NO

Please explain: ____

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Additional Comments

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Provider Contact Information

Contact Person: ____

Title: ________________________________

Phone: ________________________________

Fax: ________________________________

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