DME Medical Review Form

Neuromuscular Electrical Stimulator (NMES)

Quality and Utilization Improvement Dept.	Telephone # (888)-467-0774
DME-Medical Policy	Fax # (952) 853-8714

To be completed by a Health Professional (MD, NP, etc), not Vendor or Member.

Please answer ALL of the following questions. This information is **required** in order to determine whether coverage criteria are met.*****

Member Name:	Date of Birth:	Member #:
Completed by:	Phone #:	Fax #:

Date Completed: _____

MD ordering *(Print First & Last Name)*: _____

MD Phone #: MD Fax #:

Diagnosis: _____

Is the NMES being used as an adjunct to Physical Therapy? **YES / NO**

_____

Is the NMES being used for:

1. Treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves: **YES / NO**
2. Motor re-education? **YES / NO**
3. Decreasing spasticity, such as with cerebral palsy? **YES / NO**
4. Maintaining or increasing joint range of motion? **YES / NO**
5. Pain Control? **YES / NO**

Additional information:

_____

_____

_____

_____

_____

Physician or Treating Practitioner Signature: **Date:**

_____ _____

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