DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DME 06.03B

CMS-848 — TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HICN		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ HICN _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____	Supply Item/Service Procedure Code(s):	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1–99 *(99=LIFETIME)* | DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–6 for purchase of TENS (Check Y for Yes, N for No,)
❑Y ❑N	1. Does the patient have chronic, intractable pain?
_____ Months	2. How long has the patient had intractable pain? (Enter number of months, 1–99.)
❑1 ❑2 ❑3 ❑4 ❑5	3. Is the TENS unit being prescribed for any of the following conditions? (Check appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above
❑Y ❑N	4. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
❑Y ❑N	5. Has the patient received a TENS trial of at least 30 days?
_____/_____/_____	6. What is the date that you reevaluated the patient at the end of the trial period?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.