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Statement of Medical Necessity for Avazzia Home Units

Date:	
Patient’s Name:	
Date of Birth:	
Patient’s Address:	
Patient’s Phone Number:	
Date of Injury/Onset:	
Date of Last Office Visit:	
Diagnosis:	

Previous Treatments

☐	Acupuncture	☐	Physical Therapy
☐	Massage	☐	Other

Medications:

Results: Check the one that applies:

☐	Previous Treatments were sufficiently effective
☐	Previous treatments failed and were not sufficiently effective

Product Description: Avazzia Microcurrent TENS Device Kit

☐	Pro Sport 3™ kit	☐	BEST RSI™ kit	☐	Avazzia Blue™ kit
☐	PRO-SPORT Ultra™ kit	☐	BEST PRO-1™ kit	☐	Other

Please dispense the Device with included 2 lead wire and conductive pads plus additional lead wires

☐	4 lead wire	☐	Other

Length of Need:

☐	Less than 9 months (short term)	☐	9 months or longer (long term)
☐	Purchase for home use	☐	Other

I certify that the above prescribed treatment is medically necessary for the patient’s wellbeing.I also certify that the information noted above is accurate to the best of my knowledge.

Physician’s Signature:

DO NOT SUBSTITUTE CONFIDENTIAL INFORMATION