

PRESCRIPTION

Interferential Nerve Stimulator

by Medical Science Products, Inc.
with supplies for period of medical necessity.

PATIENT'S NAME: _____

DIAGNOSIS/ICD9 CODE(S): _____

I certify that the MSP-IF4000 Stimulator device is medically necessary as part of my treatment of this patient. The prescribed device is reasonable and necessary for the treatment of this patient's condition.
NO SUBSTITUTIONS.

PHYSICIANS SIGNATURE

Date

Please Print: _____
Facility Name and Address

Physician Name and NPI Number

Contact Phone Number

Thank You.

Fax Prescription and Patient Information to:
Medical Science Products, Inc.

Fax: 330-854-1953

Tel: 330-854-4060