

# Prescription & Letter of Medical Necessity for

## **MSP MICROCURRENT-T.E.N.S. Unit**

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

**PATIENT'S NAME:** \_\_\_\_\_

**DIAGNOSIS/ICD9 CODE(S):** \_\_\_\_\_

I certify that the MSP Microcurrent-TENS 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 with Patient Demographics and Medical Notes to:**  
**Medical Science Products, Inc.**  
**Fax: 330-854-1953**  
Tel: 330-854-4060