PRESCRIPTION &
LETTER OF MEDICAL NECESSITY

STIMULATION GARMENT

by Medical Science Products, Inc.

PATIENT'S NAME:____.

DIAGNOSIS/ICD9 CODE(S): ____

I certify that a STIMULATION GARMENT 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