PLEASE BE SURE TO READ THESE INSTRUCTIONS IN THEIR ENTIRETY TO ENSURE PROPER DOWNLOAD OF OUR NEW HOME RENTAL REQUEST AND CERTIFICATE OF MEDICAL NECESSITY FORMS.

(Note: Clinicians need to fill out these forms. There is requested information your patients will not know.)

Overview

- To use the new fillable forms, it is recommended that you open the file in Internet Explorer. We have found this to be the easiest and most user-friendly way to complete the form and electronically sign where applicable. If you don't have Internet Explorer, you can simply print the forms and fill them out manually and fax them back to us at (508) 947-1486.
- Please answer all of the questions on both pages. Please pay particular attention to the questions highlighted in red. These are required fields and will not allow you to sign or submit the document when you are done.
- You will notice that some of the information from page one is auto-populated into the second page. Before you move onto the electronic signature, please be sure you have answered all of the questions.
- Please note the "required" fields provide us with the needed information to help speed up the process between the Physical Therapist, Referring Physician and Patient. By including this information it will reduce the back and forth between each of these parties, as well as CMT Billing.

Signing the Form

- Once all of the questions are answered, you can now electronically sign the document at the bottom of page one.
- Click on the "Signature" icon located at signature line at the bottom of the first page and digitally sign the document. If you have not created an electronic signature before, you will be prompted to make one.

Saving and Submitting the Form

- Once the document is signed you will be asked to save it. Save the file as you would normally.
- Go to the bottom of the second page and click on the SUBMIT button. Both forms will be sent to Current Medical Technologies for processing.
- Please remember, we will need an actual signature from the referring physician on the Certificate of Medical Necessity.
    a. As such, print out the forms and have the Referring Physician sign and date the Certificate of Medical Necessity (i.e. page 2).
    b. Once you have obtained the Physician's signature, fax the fully executed Certificate of Medical Necessity to our DME/Billing Department at 508.947.1486.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR DME/ BILLING DEPARTMENT AT 800-382-5879 X11.

CMT Home Unit Request Form

75 Main Street, Lakeville, MA 02347
Phone: (508) 966-8240 Fax: (508) 947-1486 email: info@cmtmedical.com

Unit Prescribed

Pelvic Floor Stimulator: ☐ Pathway STM-10 ☐ Utah Medical Liberty

sEMG Biofeedback: TR10 ☐ TR10c ☐ TR20 ☐

Does patient need a sensor? ☐ Pathway Vaginal ☐ Pathway Rectal ☐ UM-Vaginal ☐ UM-Rectal ☐ Other: _____

Does patient need other accessories? _____

Billing? ☐ Self Pay ☐ Medicare ☐ Private Ins. **Purchase or Rental?** Purchase ☐ Rental ☐

Patient Demographic Information

Name: D.O.B.

Address: City: St: Zip:

Phone: Mobile Phone: Email:

Emergency Contact: Phone:

Diagnosis & ICD-10 Coding

ICD-10 Code: Choose One ICD-10 Code: Choose One ICD-10 Code: Choose One Other:

Primary Insurance

Ins. Co: Phone: Primary Insured Name:

Address: City: St: Zip:

Group# ID#:

Secondary Insurance

Ins. Co: Phone: Secondary Insured Name:

Address: City: St: Zip:

Group# ID#:

Prescribing Physician Information

Dr.'s Name: NPI#: Phone:

Address: City: St: Zip:

Physical Therapist Information

Therapist: Facility: Phone:

Address: Facility ID#

Delivery

☐ Please deliver to clinicians facility. ☐ Please deliver to my patients home.*

If ordering a STM-10 or TR-10C would you like it programmed? ☐ Yes ☐ No

STM-10: Session Time: _____ Duty Cycle: _____ Stim Mode: _____

TR-10C: Goal: Above ☐ Below ☐ Work-Rest 5/10 ☐ Work-Rest 10/10 ☐ Scale: 800UV ☐ 30UV ☐

Clinician Name: _____

Clinician Signature: _____ Date: _____

Email Address: _____

*My above signature indicates my approval of this order and it's accuracy. *My above signature indicates my approval to ship the instrument to my patient's home and releases Current Medical Technologies, Inc. from any liability from it's use prior to proper instrument education and training. Please note, due to state regulations we are not allowed to ship direct to Tennessee residents.*

CMT Certificate of Medical Necessity

Current Medical Technologies, Inc., 75 Main St., Lakeville, MA 02347
Phone: (508) 966-8240 **Fax (508) 947-1486** www.cmtmedical.com

The following information is being requested to document the medical necessity for the rental or purchase of a home DME unit.

This form must be completed and signed by the patient's attending physician to be valid.

Patient Information:

Patient Name:_____

Patient Address:_____

City:_____

State:_____ Zip:_____

Phone #:_____

Date of Birth:_____

Unit Prescribed:

☐ Pelvic Floor Stimulator ☐ sEMG Biofeedback

Length of Need:

☐ Purchase (1 -99 = Lifetime)
☐ Rental #_____ Months

Medical Necessity / Physician's Order

As the Referring Physician, I hereby certify that the medical necessity information provided on this form is accurate and complete to the best of my knowledge.

Physician Name:_____
Facility Name (if applicable):_____
Address :_____
City, State & Zip Code_____
NPI#_____ P.E.C.O.S. Certified? _Yes _NO
Physician Signature:_____
Date of Signature:_____
Email Address:_____

***Please Note: Medicare will no longer accept rubber signature stamps.**

Please make sure the above information is substantiated in your patients' medical record.

Medical Necessity Information

Diagnosis:

☐ N31.9 Detruser Instability
☐ N94.89 Pelvic Pain, female
☐ M6240 Muscle Spasm, Unspecified site
☐ N3941 Urge Incontinence
☐ N393 Stress Incontinence, male
☐ N393 Stress Incontinence, female
☐ N3946 Mixed Incontinence
☐ R159 Fecal Incontinence
☐ M6281 Muscle Weakness
☐ Other:_____

PFS is prescribed to: (Check all that apply)

☐ Improve Urethral Closure Function
☐ Improve Urethral Sphincter Function
☐ Inhibit Unwanted Bladder Contractions
☐ Inhibit Irritable
☐ Other:_____
☐ Other:_____

Are the pelvic nerves intact?

☐ YES ☐ NO

Prognosis:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has the patient had an in-office visit with the Ordering Physician within six months prior to the Date of Signature? YES ☐ NO ☐

Anticipated Benefit From Use:

☐ Increase Pelvic Muscle Strength
☐ Increase Pelvic Muscle Coordination
☐ Hypertrophy of Pelvic Muscles
☐ Decrease Urinary Leakage
☐ Increase Voiding Interval
☐ Neuromuscular Re- Education
☐ Decrease Involuntary Detruser Contractions
Other:_____

Has patient failed a 4 -week trial of Pelvic Muscle Exercises? ☐ YES ☐ NO

"If YES, was the trial documented?"

☐ YES ☐ NO

SUBMIT