Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) UNITS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Height (in.) Weight (lbs.)	Telephone number	
Address*	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Description of requested unit

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation
Rental ☐ For neurogenic pain: The individual is experiencing intractable, nerve-related pain that has lasted at least six months. The use of a comparable TENS unit for at least thirty days produced substantial relief from pain ☐ *and, if applicable,* enabled a significant reduction in medication (e.g., muscle relaxants, narcotics, analgesics). Initial 30-day period: from ___/___/_____ to ___/___/_____	☐ For post-operative pain: Treatment lasting no longer than thirty days is needed for acute pain following surgery. Date of surgery: ___/___/_____
	☐ The use of more than two leads is medically necessary.
Purchase ☐ Continued treatment after the initial rental period is medically necessary.	

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.