Signal Health Group
3753 Howard Hughes Parkway #200
Las Vegas, NV 89169

Letter of Medical Necessity
Implantable Neurostimulator, Pulse Generator, any type

Patient: _____ Address: _____
City: _____ State: _____ Zip: _____

Does the patient have a chronic, intractable pain? ☐ Yes ☐ No

Is there documentation in the patient's record conservative and/or medication therapies that have been tried and failed? ☐ Yes ☐ No

Diagnostic Information

Primary Diagnosis Code: _____
Secondary Diagnosis Code: _____

Based on the patient's history, examination, and diagnosis below I'm prescribing:

- ❑ L8679 Implantable neurostimulator, pulse generator, any type

Expected Benefits of/need for the Implantable neurostimulator relief of one or more of the following conditions:

- ❑ Back pain
- ❑ Cervical pain
- ❑ Fibromyalgia
- ❑ Migraines
- ❑ Chronic pain
- ❑ Sciatica
- ❑ Arthritic and joint pain
- ❑ Zoster related pain
- ❑ Localized and referred pain

Instructions for Use:
Frequency of use _____ times per week / month
Duration of treatment _____weeks / month

Date of Examination: _____

Physician's Name: _____

Physician's NPI: _____

_____
Physician's Signature Date