Free Evaluation / Trial Prescription

Not a Request for Authorization: Free Trial Prescription of Home H-Wave

Patient _____ Sex: ☐ SSN _____

Address _____ HM# _____ WK# _____

City_____ State_____ Zip_____

Employer _____ Phone _____ Claim No _____

Address_____ City_____ State_____ Zip_____

Ins. Co _____Adjuster/Ext _____Phone _____Fax _____

Address_____ City_____ State_____ Zip_____

Case Manager _____ Phone _____Fax _____

Date of Injury _____ Date of Birth _____ Language _____ R#_____ F#_____

Attorney Name _____Phone _____ Fax _____

Address_____ City_____ State_____ Zip_____

☐ **If checked please see attachment for corrected patient demographics**

DIAGNOSIS

1._____ ICD-10_____

2._____ ICD-10_____

TREATMENT PLAN AND PRESCRIPTION

Free 30-Day Trial of the H-Wave Homecare System to evaluate effectiveness

Treatment Rx: Two times per day @ 30-60 minutes per treatment PRN. After a 30 day trial, if the patient obtains relief and/or shows functional improvement, this prescription allows continued and ongoing home use as instructed.

Treatment Goals: 1) To reduce and/or eliminate pain 2) To improve functional capacity and activities of daily living
3) To reduce or prevent the need for oral medications 4) To improve circulation and decrease congestion in the injured region
5) To decrease or prevent muscle spasm and muscle atrophy 6) To provide a self-management tool to the patient

H-Wave is an evidence based treatment that focuses on functional restoration. A trial of the H-Wave device is addressed and is in accordance with the Official Disability Guidelines "Chronic Pain Section" and "Low Back Section". Numerous studies indexed by Medline and PubMed.gov (http://PubMed.gov) have shown the H-Wave to improve function and reduce medication usage. A trial of this safe, drug free treatment is both reasonable and medically necessary at this time.

Primary Treating Physician **☒ Do Not Substitute**

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Address_____ City_____ State_____ Zip_____

Phone _____ Fax _____ Contact _____

Name _____Specialty _____ License # _____

Signature _____ Date _____