VEINOPLUS® MEDICAL PRESCRIPTION

1. Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Cell Phone: _____

2. Neuromuscular Electrical Stimulation Therapy Program

- ☐ Disuse Muscular Atrophy (M62.561) Right Lower Limb
- ☐ Disuse Muscular Atrophy (M62.562) Left Lower Limb
- ☐ Atrophy (A4595) Electrodes

Nerve supply is intact with the calf muscle? ☐ Yes ☐ No

3. Prescription Supplements

- ☐ Copy of physician's RX
- ☐ Patient demographic sheet
- ☐ Insurance card (or insurance information)
- ☐ Chart visit notes with the following statement included, "Ordering muscle stimulator (VEINOPLUS) for disuse muscular atrophy M62.562 and/or M62.561"

4. Treatment Instructions: NMES Device-E0745

Perform one-hour session ☐ 1 ☐ 2 ☐ 3 ☐ _____ times per day.

5. In-Person Encounter Certification

I certify this patient is under my care, has been seen within six (6) months of this order, supports the CMS NCD policy, and meets the need of this medical equipment.

Prescriber: _____

Order Date: _____ NPI: _____

Address: _____

City: _____ State: _____ ZIP: _____

Signature: _____

DynaPulse Medical

13500 Wayzata Blvd
Minnetonka, MN 55305-1850

DYNAPULSE MEDICAL

Ordering

No substitutions; supply as written.

To order, please email or fax all information to:
orders@soliditymedical.com or 844-444-1183

Fulfilled through Solidity Medical on behalf of DynaPulse

Customer Care

Email: customer.service@dynapulsemedical.com
Hours: 7:00 AM - 7:00 PM CT Monday-Friday

Local Sales Representative

Name: _____
Phone Number: _____
Email: _____
ID Number: _____