Electromedical Products International, Inc.
2201 Garrett Morris Parkway
Mineral Wells, TX 76067-9034 USA
(940) 328-0788 Fax: (940) 328-0888

www.**alpha-stim**.com
email: alpha-stim@epii.com
1.800.FOR.PAIN (367-7246)

Statement of Medical Necessity for Alpha-Stim® Purchase

Please print or type all * required fields

Claim# (if applicable) ____

PATIENT INFORMATION

*Patient Name ______________________ Date of Birth ______________________

*Responsible Party (if applicable) ____

*Address ____

*City ______________ *State __________ *Zip __________ *Country ______________

*Phone ______________________ Email ______________________

To Whom It May Concern:

I am ordering the purchase of an Alpha-Stim® prescription electromedical device complete with accessories for the above named patient to use at home as a conservative method of treatment.

I want this patient to have the following Alpha-Stim® device (*do not substitute*). Use as directed:

- ☐ **Alpha-Stim® M** microcurrent stimulator for the control of pain, anxiety, depression, and/or insomnia.
- ☐ **Alpha-Stim® AID** cranial electrotherapy stimulator for the treatment of anxiety, depression, and/or insomnia.

The patient's current diagnosis applicable to the Alpha-Stim® treatments is:

______________________________ ICD10 Code: ______________________

______________________________ ICD10 Code: ______________________

Yours truly,

LICENSED HEALTHCARE PRACTITIONER INFORMATION

*Name, Degree ____

*NPI ______________________ *State License/NPI ______________________

*Address ____

*Phone ______________________ Fax ______________________

*City ______________ *State __________ *Zip __________ *Country ______________

Email ______________________ Rep Name ______________________

***Signature** ______________ **Dispense Date** (Valid for 1 year from dispense date) ______________