HealthPartners

Neuromuscular Electrical Stimulator (NMES)

DME Medical Review Form

To be completed by a Health Professional (MD, NP, etc.), not Vendor

Member name:	Date of birth:	Member #:
Completed by:	Phone #:	Fax #:

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed Tax ID#:
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-10:

Is the NMES being used as an adjunct to physical therapy following a successful trial in an appropriate clinical setting?
☐ Yes ☐ No

Is the NMES being used for:

1. The treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves? ☐ Yes ☐ No
2. A non-neurological reason for disuse atrophy due to casting or splinting, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery? ☐ Yes ☐ No
   If yes, please explain in the 'additional information' space below.
3. Motor re-education? ☐ Yes ☐ No
4. Decreasing spasticity, such as with cerebral palsy? ☐ Yes ☐ No
5. Maintaining or increasing joint range of motion? ☐ Yes ☐ No
6. Pain control? ☐ Yes ☐ No
7. If requesting continued rental, how many more months is the NMES needed? _____

Additional information:

_____
_____
_____
_____

I confirm that the information above is correct.

Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333
Please include fax cover sheet when submitting.