group health Cooperative of eau claire

Authorization Request Form

TENS Evaluation

Member Name: _____ DOB: _____ ID#: _____

Provider Name: _____ Fed#: _____ NPI#: _____

Ordering Physician: _____

Diagnosis Code: _____ CPT Code: _____
(please send a copy of the doctors order with this request.)

Type of Pain:

Acute postoperative pain *(choose those that apply)*:

- ☐ Less than or equal to 30 days since surgery
- ☐ Pain unresponsive to parenteral or oral pain medication
- ☐ Other clinical information

Chronic intractable pain *(choose those that apply)*:

- ☐ Initial application
- ☐ Pain Greater or equal to 3 mos: ☐ yes or ☐ no (choose one)

Ongoing application (choose those that apply):

- ☐ 30-day TENS trial completed
- ☐ Reduction in pain during trial
- ☐ TENS reevaluation documented
- ☐ TENDS unit to be used at least once daily
- ☐ Other clinical information

Etiology of pain amenable to TENS treatment *(choose one)*:

- ☐ Musculoskeletal
- ☐ Neurogenic
- ☐ Other clinical information

Continued pain after *(choose those that apply)*:

- ☐ Pain medications
- ☐ Pain reliever modalities
- ☐ Other clinical information

Treatment area *(choose those that apply)*:

- ☐ Treatment across a joint
- ☐ Large area of pain
- ☐ Adipose tissue interferes with conduction
- ☐ Treating two separate areas with two leads simultaneously
- ☐ Failed 2 lead unit trial
- ☐ None of the above