Statement of Medical Necessity for Alpha-Stim® Purchase

Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell 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 treating pain, anxiety, depression and/or insomnia. This technology is supported by successful outcomes documented by more than 80 published articles (see **www.alpha-stim.com** for annotated abstracts). It has shown to be consistently effective so I have advised the patient to utilize it on a regular basis.

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

☐ **Alpha-Stim® M** microcurrent stimulator for the treatment 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 diagnoses applicable to the Alpha-Stim® treatments are:

1. _____ ICD10 Code: _____
2. _____ ICD10 Code: _____
3. _____ ICD10 Code: _____
4. _____ ICD10 Code: _____

Yours truly,

PHYSICIAN INFORMATION

Name, Degree _____

NPI _____ State License/UPIN _____

Address _____ Phone _____

_____ Fax _____

_____

City _____ State _____ Zip _____

Signature _____

Solace Medical, LLC
20436 Route 19, Suite 255
Cranberry Twp., PA 16066
Phone: 412-345-7899

Please fax the completed form to: 888-245-0250