

Statement of Medical Necessity for Alpha-Stim

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](http://www.alpha-stim.com) and [www.mybrainchemistry.com](http://www.mybrainchemistry.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 \_\_\_\_\_