Send signed Rx along with patient demographics & most recent office note to **neworders@gatewaymedical.net** or fax to: (636) 489-1564

RX, Pre-Auth & Medical Necessity Certification

Patient Name:_____ DOB:_____

Rx:

☐ E0748 CMF Spinalogic Osteogenesis Stimulator, electrical, non-invasive, spinal applications

Diagnosis:

☐ _____ _____ ☐ _____ _____

☐ _____ _____ ☐ _____ _____

☐ _____ _____ ☐ _____ _____

Planned Procedure:

Planned Procedure:_____ Fusion Levels:_____ to _____

Other:_____

Prior Surgical Procedures:

☐ Fusion Surgery Date: ____ / ____ / ____ Fusion Levels:_____ to _____

☐ Discectomy Date: ____ / ____ / ____ Fusion Levels:_____ to _____

☐ Laminectomy Date: ____ / ____ / ____ Fusion Levels:_____ to _____

☐ Other Date: ____ / ____ / ____ Fusion Levels:_____ to _____

All that apply are checked:

☐ Multi-Level Fusion	☐ Obesity	☐ Diabetes
☐ Mixed Graft	☐ Tobacco Use (____ppd)	☐ Arthritis
☐ Allograft	☐ Failed Fusion	☐ Alcohol Use
☐ Autograft	☐ Osteoporosis	☐ Spondylolisthesis
☐ Advanced Age	☐ History of Smoking	☐ Vascular Disease
☐ Renal Disease	☐ Long term steroid use	☐ NSAIDS
☐ Previous Back Surgery	☐ Stenosis	☐ Other: _____

Date of Service: ____ / ____ / ____ Length of Treatment: _____ (number of months)

My signature below means that, in my judgement, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. My signature also serves to confirm the veracity of all information included in this document.

Physician's Signature:_____ Printed:_____

NPI:_____ Date:_____