**Senergy Medical Group**
**9901 Valley Ranch Parkway East, Suite 1009**
**Irving, TX 75063**
**Office 972-580-0545, Fax 214-260-7765**
**www.senergy.us**

Dear Patient:

To better support you in filing your insurance paperwork for the Tennant Biomodulator, we are supplying the information listed below. We suggest you submit a pre-authorization request to your insurance carrier and follow through with faxing or mailing your claims paperwork to them for processing. You can expect a minimum of 30 to 45 days before you receive an answer. We encourage you to follow-up with your carrier once you have filed to be sure they are in receipt of the paperwork.

**In submitting your claim, you will need the following information:**

1. Photocopy of the Front and Back of Your Insurance card
2. Your Prescription (this must state "Pain")
3. Two (2) Page Letter of Medical Necessity Form - To be filled out by Doctor.
4. Conductive Garment Medical Necessity Form (if applicable) - To be filled out by Doctor.

It is my understanding that the doctor needs to document that a TENS unit has been used on the patient successfully. The doctor needs to state that the patient requires the unit at least 99 months or permanently. ***The prescription faxed to Senergy must show a diagnosis*** for " ***a condition with pain***" ***written on the prescription with the order for a*** " ***Tennant Biomodulator -*** No Substitutions" .

There are 3 CPT codes for the Biomodulator that insurance may consider. These are:

**E0720 (TENS)**
**E0731 (Garment)**
**A4595 (Wires, Patches, Electrodes)**

You will need to call your insurance company to make sure your insurance covers these codes. Ask them to tell you what they pay on each of these codes as the reimbursement may vary.

**When calling ask:**

1. Are you covered for out-of-network services? If so, what is the reimbursement? (In some cases, your insurance carrier will pay for the Biomodulator as "In -Network" as there are no other distributors who carry our product.)
2. What is your annual DME (Durable Medical Equipment) coverage for both in-network and out-of-network vendors. (If they say you will be covered 100%, do not assume they are talking about the total cost of the Biomodulator -*ASK them to be very clear with you*. Most of the time they are talking about the **annual** DME Coverage).
3. Do you have a deductible for DME purchases, and has your deductible been met for this plan year?
4. Document the name and phone number of the insurance person (benefits representative, claims adjuster, etc.) you speak with, date of call, and what they tell you. You may need this to refer to later.

Feel free to call with any questions. We look forward to seeing you at a future course.

**Get Well - Be Well - Live Well,**

**Tamara Bagwell**

# INSURANCE VERIFICATION WORKSHEET

***(FOR INDIVIDUAL'S USE ONLY-NOT TO BE SENT TO SENERGY OR THE INSURANCE COMPANY)***

**Insured's Name:** _____

**Insured's Policy Number:** _____

**Insured's Group Number (if relevant):** _____

**Referring Physician:** _____

**Diagnosis (Prescription should state for PAIN and BIOMODULATOR-NO SUBSTITUTIONS):**

_____

***BE CERTAIN TO DOCUMENT THE COMMUNICATION WITH THE INSURANCE CARRIER:***

**Date of Contact:** _____

**Name of Person With Whom You Have Spoken:** _____

**Phone Number/Extension of Party Contacted:** _____

**BENEFITS VERIFICATION:**

- **Do I have DME (Durable Medical Equipment) coverage?** _____
- **What is my deductible for DME benefits?** _____
- **Has my DME deductible been met for this plan year?** _____
- **What is my TOTAL ALLOWABLE coverage per year for DME?** _____
- **Does my plan cover me for "Out-of-Network" coverage?** _____
- **If so, then at what percentage?** _____
- **Would my plan consider reimbursement of Biomodulator as "In-Network"?** _____
- **If yes, then at what percentage?**
- **What is my co-payment for DME?** _____
- **What is my "Out-of-Pocket" expense for DME?** _____
- **Has my "Out-of-Pocket" expense been met?** _____
- **Does my plan require Pre-Authorization for a TENS unit?** _____
- **What does my plan pay for the following CPT Codes?**
    - **E0720 (TENS)** _____
    - **E0731 (Garment)** _____
    - **A4595 (Wires, Patches, Electrodes)** _____

# LETTER OF MEDICAL NECESSITY

***TO BE COMPLETED IN FULL BY PRESCRIBING PHYSICIAN***
*****RETURN TO SENERGY MEDICAL GROUP with PRESCRIPTION***
***AND SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT***

**Patient Name:** _____

**Patient Address:** _____

**Date of Birth:** _____

**Date of Service:** _____

**Please be advised that this patient has been under my professional care.**

***DIAGNOSIS (ICD-9 CODES):*** _____

_____

***SUBJECTIVE COMPLAINTS:*** _____

_____

***OBJECTIVE CLINICAL EXAMINATION FINDINGS:***

**Decreased Range of Motion in the following regions (check which apply):**

- **Cervical** _____
- **Thoracic** _____
- **Lumbar** _____
- **Other** _____

**Muscle spasms in the following regions (check which apply):**

- **Paracervical** _____
- **Paradorsal** _____
- **Paralumbar** _____
- **Other** _____

**Parasthesia in the following extremities (check which apply):**

- **Upper Left** _____
- **Upper Right** _____
- **Lower Left** _____
- **Lower Right** _____

**Moderate to severe pain in the following regions (check which apply):**

- **Cervical** _____
- **Thoracic** _____
- **Lumbar** _____
- **Other** _____

***OTHROPEDIC AND NEUROLOGICAL FINDINGS:***

_____

_____

***ALTERNATIVE TREAMENT OPTIONS THAT HAVE BEEN USED WITHOUT SUBSTANTIAL PAIN RELIEF:***

_____

_____

***DURATION OF CHRONIC PAIN SYMPTOMS:*** _____

***STATEMENT OF MEDICAL NECESSITY:***

**Positive clinical findings of an objective exam, as noted above, reasonably verify, clinically support and substantiate the long-term use and medical necessity of a TENS unit, and supplies, for pain control. The patient has benefited from a trial period of electrical muscle stimulation and in my opinion, would continue to benefit from an on-going home program of TENS therapy for symptomatic relief of pain.**

**After evaluation and examination of this patient, I am recommending and prescribing the Tennant Biomodulator Plus, with NO SUBSTITUTIONS, for use to relieve pain symptoms (Check all that apply).**

**Tennant Biomodulator Plus (TENS)** _____
**All Necessary Supplies (electrodes/patches/wires)** _____
**Conductive Garments (Please Check Item that Applies):**
**Glove** _____ **Sleeve (Arm/Leg)** _____
**Sock** _____ **Other** _____

**I certify that the above prescribed TENS unit and supplies are medically necessary for long-term to permanent use as part of my treatment program for this patient.**

_____ _____
**Physician's Signature** **Date**

_____ _____
**Physician's Name (printed)** **NPI Number**

_____
**Physician's Address**

_____ _____
**City/State/Zip** **Phone Number**

# LETTER OF MEDICAL NECESSITY
# for
# Conductive Garments

***TO BE COMPLETED IN FULL BY PRESCRIBING PHYSICIAN***
*****RETURN TO SENERGY MEDICAL GROUP with PRESCRIPTION***
***And***
***SUBMIT TO YOUR INSURANCE COMPANY, IF APPLICABLE***

**Patient Name:** _____

**Patient Address:** _____

**Date of Birth:** _____

**Date of Service:** _____

***Please be advised that this patient has been under my professional care.***

**Please check all that apply:**

_____ The patient has a large area or multiple sites to be stimulated and the stimulation would have to be delivered so frequently that pain cannot be managed by using conventional electrodes, adhesive tapes and lead wires.

_____ The patient's chronic intractable pain is located in areas that are inaccessible with the use of conventional electrodes.

_____ The patient has a medical condition (i.e. skin condition) that prevents the use of conventional electrodes.

_____ The patient requires electrical stimulation beneath a cast.

_____ The patient has a medical need for rehabilitation strengthening following an injury where the nerve supply to the muscle is intact.