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Dear Patient:

As Senergy Medical Group does not file insurance paperwork or accept insurance assignments, we have prepared this information to better support you in filing your insurance paperwork for the Tennant Biomodulator. 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 to your insurance carrier, you will need the following information:

1. Photocopy of the Front and Back of Your Insurance card
2. Your insurance company's claim form for Durable Medical Equipment (DME)
3. Your Prescription (this must state a legitimate "Pain" diagnosis and state **"Biomodulator-NO SUBSTITUTIONS")**
4. Two (2) Page Letter of Medical Necessity Form - To be filled out by Doctor (DO NOT SEND TO SENERGY).
5. Back-up documentation from your physician, if requested by the insurance carrier.
6. Conductive Garment Medical Necessity Form (if applicable) - To be filled out by Doctor.

It is our 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 codes, referred to as HCPC or CPT codes, for the Biomodulator and Biotransducer 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 your insurance company, we suggest you ask the following questions:

1. Does your policy cover 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.) Let your insurance know that **Senergy is a "sole source provider"** of the Biomodulator.
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. Does your deductible include DME purchases, is it a separate deductible, 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.

Get Well - Be Well – Live Well,

Tamara Bagwell
Patient Educator

INSURANCE VERIFICATION WORKSHEET

Use this worksheet when calling your insurance company.

(FOR INDIVIDUAL'S USE ONLY-DO NOT SEND 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 To Whom You Have Spoken: _____

Phone Number / Extension of Party Contacted: _____

SUGGESTED QUESTIONS TO ASK FOR 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" since Senergy is a "sole source provider"?** _____
- **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 or HCPC Codes?**
  - **E0720 (TENS)** _____
  - **E0731 (Garment)** _____
  - **A4595 (Wires, Patches, Electrodes)** _____

LETTER OF MEDICAL NECESSITY

TO BE COMPLETED IN FULL BY PRESCRIBING PHYSICIAN
*****MAIL OR FAX PRESCRIPTION ONLY TO SENERGY MEDICAL GROUP***
SUBMIT FORMS AND PRESCRIPTION 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** _____

ORTHOPEDIC AND NEUROLOGICAL FINDINGS:

_____

_____

ALTERNATIVE TREATMENT 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, with NO SUBSTITUTIONS, for use to relieve pain symptoms (Check all that apply).

Tennant Biomodulator (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
*****FAX PRESCRIPTION ONLY TO SENERGY MEDICAL GROUP***
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.

_____ _____
Physician's Signature **Date**

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

_____
Physician's Address

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