SAFE & EFFECTIVE RELIEF

AlleviaHealth
For healthy mind and body

2023 STATEMENT OF MEDICAL NECESSITY

To whom it may concern,

I am ordering the purchase or rental of an Alpha-Stim® electromedical device complete with accessories for the below named patient to use at home as a conservative method of treating anxiety, insomnia or pain. This technology is supported by successful outcomes documented by more than 140 published articles (Abstracts and PDFs of research articles are available at www.Alpha-Stim.com).

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

☐ Alpha-Stim® M microcurrent stimulator for treatment of pain, anxiety and insomnia

☐ Alpha-Stim® AID cranial electrotherapy stimulator for treatment of anxiety and insomnia

Allevia Health, Inc. provides detailed printed instructions and follow-up support by phone for patients who purchase or rent an Alpha-Stim®. Alpha-Stim® devices come with a 5 year manufacturer's warranty.

PATIENT

Name_____

Address_____

_____

City_____State_____Zip_____

Home Phone (_____)_____

Cell Phone (_____)_____

Email_____

Date of Birth_____

FAX form to (888) 684-8414

or email it to: info@alleviahealth.com

or mail it to:
Allevia Health, Inc.
Authorized Distributor for OR & WA
20 E Airport Road, Suite 342
Lebanon, OR 97355

Questions? (800) 684-9343

www.AlleviaHealth.com

PRACTITIONER

Practitioner's Name_____

Practitioner's Signature_____

Degree_____State License #_____

NPI#_____

Office/Clinic_____

Street Address_____

City_____State_____Zip_____

Phone (_____)_____Fax (_____)_____

Date Ordered For Patient_____

The patient's current diagnoses applicable to the Alpha-Stim® treatments are:

1. _____ ICD10 Code_____

2. _____ ICD10 Code_____

3. _____ ICD10 Code_____

4. _____ ICD10 Code_____