current technology

Request for Prior Authorization for Insurance Coverage

(s) EMG Unit:

☐ **TR-10 (single ch.)** ☐ **TR-20 (dual ch.)**

☐ **MR-10 (single ch.)** ☐ **MR-20 (dual ch.)**

☐ **U-Control** ☐ **Myotrac 4000**

E. Stim Unit:

☐ **STM-10** ☐ **Liberty**

Accessories:
#6320 _____ #6330 _____ # 6340 _____
#T6050 _____ #T6051_____

#PFS-041 ___ #PFS-042____ #PFS-043 ___

#6750 ____ #5328 _____ # H59P_____

Patient Name ___________________________________**Telephone No.**____________________
(Pt. will not be contacted during the prior auth. process)

Patient Address ____
(Street) (City) (State) (Zip)

Patient's SSN: _____________________________________**Patient's Date of Birth** __________

Diagnosis: ____**Diagnosis Code(s):**_____________

Policy Holder
Name: ___________________________________**Relationship to patient** __________________

Policy Holder
SSN: ____________________________**Employer** ___________________**Date of Birth**________

Prescribing Physician's Name ____

Insurance Company Name ____

Telephone Number: ____

Claim Representative / Agent / Case Mgr. Name ______________________________________

POLICY NUMBER ____________________________________**GROUP NO.** _________________

If WORKER'S COMP OR AUTO – DATE OF INJURY:_______________**CLAIM NO.**_____________________

FAX TO: Current Technology, Inc. AT 763-588-0066 OR CALL 800-322-4461

*****NOTE: MEDICARE FOR E.STIM REQUIRES A DIFFERENT FORM –PLEASE CALL OUR OFFICE – MEDICARE FOR BIOFEEDBACK IS NOT COVERED AND THE PATIENT WOULD NEED TO BE ON " SELF-PAY" BASIS. THANK YOU.**