BIOWAVE
SMARTER PAIN BLOCKING TECHNOLOGY

Clinically Proven
Non-Opioid Pain Relief

BioWavePENS

Pain relief treatment at the doctor's office

PENS Pre-Authorization Form

PENS Pain Relief Bundle

Treatment in Doctor's Office

PAIN RELIEF in 5 Easy Steps:

1. Identify patient pool based on payors
2. Doctor sends completed PENS Pre-Authorization form and patient notes to BioWave
3. BioWave gets approval from insurance carrier for 6 PENS treatments
4. Doctor buys PENS Pain Relief Bundle from BioWave
5. Doctor performs 6 pre-approved PENS treatments and bills insurance carrier

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PRE-AUTHORIZATION REQUEST FORM

CONFIDENTIAL- Fax or email completed form and supporting clinical documentation to: 1-475-444-3443 or preauthorizations@biowave.com

OFFICE INFORMATION			
PHYSICIANS NAME:		Contact Name:	
State:		Email:	
NPI:		Phone:	
TIN:		Fax:	

PATIENT INFORMATION			
PATIENT NAME:		Date of Birth:	
Insurance:		Policy #:	
ICD 10 Codes: (please list only for the ONE region – area to be treated)			

QUALIFIYING INDICATIONS FOR SERVICES					
Patient Age		Pain Level: (1-10)		Functional Mobility (i.e. 15%)	
Prior Failed Treatments:	☐ Bracing ☐Epidurals ☐Injections ____ ☐ PT/OT/Aquatic Therapy ☐ RFA ☐ TENS ☐ Surgery_____________________ ☐ Other____				
Patient Failed Medications:	☐ Anti-depressants ☐Muscle Relaxants ☐ Narcotics ☐ NSAIDS ☐ Opioids ☐ Steroids ☐ Other ____				
Limited Activities of Daily Living:					

Please Attach the Following to this Completed Form:

- ☐ Patient Demographic Sheet
- ☐ One Office Note
- ☐ Insurance Card (Front & Back) or Worker's Comp/Auto Info (Adjuster Phone, DOI, Claim Number)
- ☐ **AETNA ONLY:** MRI/CT Scan Report

PHYSICIAN CERTIFICATION

By submitting this form to Biowave, the physician identified above completed this document in its entirety (or reviewed it carefully after it was competed by an employee under their direction) and the information provided by the physician/physician's staff, including the patient diagnosis, and medical documentation supporting PENS is true, accurate and complete to the best of their knowledge. The physician also certifies that this treatment is medically necessary.

Physician's Signature: ____ **Date:** ____