Bone Stimulator Questionnaire
(Provider)

Participant: ______________________________ **SSN:** ______________________________

Patient: ______________________________ **Date:** ______________________________

The Plan covers services considered reasonable and necessary in connection with the diagnosis and treatment of any non-industrial illness or injury. The information provided below will assist us in expediting your request.

Diagnosis: ______________________________

Indications for Stimulator (Clinical Details):

____

____

____

____

Fracture Repair Date:______________________________

X-Ray Findings (Dates): ______________________________

____

____

Type of Stimulator Prescribed:______________________________

Your cooperation is appreciated.

Physician's Name: ______________________________**License #**____________________

Address: ______________________________

Telephone: ______________________________**FAX** ______________________________

____

Physician's Signature **Date**

Return completed form to the Medical Review Department:
MPIHP, P.O. Box 1999, Studio City, California 91614-0999

rev.BoneStimulator.Frm 5/05