

To submit a prescription, please follow these steps:

- 1. Complete the Prescription Form.
- 2. Send the **Prescription Form** and **Chart Notes** from the visit during which Felix was prescribed or the most recent visit to

Fax: 800-673-3999



8500 Normandale Lake Blvd., Suite 400B, Bloomington, MN 55437-5543 Phone: 800-798-6777 Fax: 800-673-3999 Email: support@fasiklmed.com

NON-MEDICARE Felix NeuroAl™ Wristband for Tremor Relief – Prescription Form

Patient Information

First Name:		Last Nan	Last Name:		
Policy Number:	Date of E	Date of Birth:			
Address:					
0''		0.1		T	
City:		State:		Zip Code:	
Email: Mobile Phor		ne:		Home Phone:	
		110.	''		
L					
Diagnosis ICD-10 Cod	e				
☐ G25.0 : Essential tre					
□ 025.0. Essential tre	moi				
☐ Other:					
L					
External Upper Limb T	remor Stimulator Des	crintion			
Felix NeuroAl™ Wris					
HCPCS Code		GIIIOI			
	External upper limb trer	nor stimulator	of the periph	eral nerves of the wris	t
Felix NeuroAl™ Elect			<u> </u>		
HCPCS Code	: A4542				
	Supplies and accessori	es for externa	I upper limb	remor stimulator of the)
	ves of the wrist		00 d	_	
Quantity: 1 (9	u-day suppiy) Reti i	I frequency:	every 90 day	S	
Prescriber Authorizati					
Treating Practitioner		Order Date:			
Total Company (Company)	NI			NDI#	
Treating Practitioner	Name:			NPI#	
Clinic Name:		l Em	nail Address		
Chilic Name:		Em	iaii Audress		
Phone Number:	Fas	Fax Number:			
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Please fax the completed form to 800-673-3999.