BIONESS PoNS PRESCRIPTION

PoNS®
Portable Neuromodulation Stimulator

ALL SECTIONS MUST BE FILLED OUT COMPLETELY

Patient Information

Patient Legal Name: First	MI.	Last	
Street Address:	City:	State:	Zip:
Patient DOB: MM/DD/YYYY	Phone:		

Device and Diagnosis

☐ PONS Device (1 Controller and 1 Mouthpiece) Quantity _____	☐ PONS Controller Quantity _____	☐ PONS Mouthpiece Quantity _____
Primary Diagnosis Dx Code _____ ICD-10 code Dx Code _____ ICD-10 code		

Other

Physical Therapy Required

PHYSICIAN INFORMATION		
Physician:	License #:	NPI #:
Physician's Signature:	Date:	
I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary for this patient's treatment.		

Upon completion, fax this form to Bioness Client Relations Department
Fax: 877.362.4855 | Phone: 800.211.9136 option 2

918-00107-001 Rev. A
06/2026

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