PAIN TUNER PRO

Letter of Medical Necessity

The Rezzimax® Pain Tuner Pro is a US FDA registered medical device. The Pain Tuner Pro is a specially calibrated variable frequency resonance tool that trains the vagus nerve, promoting relaxation and calm throughout the brain and body, where healing potential is encouraged.

Unlike other vibration devices, the Pain Tuner Pro's actions and outcomes are built on the concept of resonance entrainment – where an increased activation of a system is such that when the frequency of an applied force (Pain Tuner Pro) is equal or close to that of the system being stimulated, a natural balancing force is created (a tuning effect).

Results commonly seen with the Pain Tuner Pro:
1) Relaxation
2) Decreased stress response
3) Improved muscle tone
4) Improved mental clarity
5) Decreased pain
6) Decreased inflammation
7) Increased blood flow
8) Improved balance

Conditions commonly helped by the Pain Tuner Pro:
1) Anxiety and headaches
2) Traumatic and acquired brain injury, concussion, stroke, seizures, etc.
3) Functional neurological disorders/conversion disorders
4) Learning and behavioral disorders (ADHD, OCD, addiction, etc.)
5) Movement and balance disorders
6) Pain syndrome
7) Cognitive impairment and dementia
8) Peak athletic, academic, and artistic performance

If a medical or dental professional has diagnosed a medical condition and recommended a Rezzimax® Pain Tuner Pro as a treatment mitigation for the medical condition, under many government guidelines it should qualify for reimbursement through available health plans.

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Medical and Dental professionals: If your patient participates in a qualified health program and they purchase a Rezzimax® Pain Tuner Pro pursuant to your recommendations to treat or mitigate a medical condition you have diagnosed, your patient may be eligible for reimbursement or tax-preferred treatment under his/her health plan (subject to any additional limitations or conditions of the plan).

Mail or fax this form (and a copy of your receipt) to your Health Plan Administrator (and/or retain for your records).

To Be Completed for Patient:

I certify that the expenses I am claiming are a direct result of the medical condition described below, and that I would not incur this expense if I were not treating or mitigating this medical condition.

Patient Name: ____

Participant Name/Employer: ____

Member Number: ____

Diagnosis: ____

Treatment: ____

Signature of Attending Medical Professional: ________________________________Date: ____________

Medical Professional Printed Name (First & Last): ____

Address: ____**Telephone Number:** (____) ____________