



Uplink is a by prescription-only Cranial Electrotherapy Stimulator. Authorization must be obtained from a healthcare provider who is licensed in the state in which he or she practices.

	Patient Informat	ion		
Name:			Date of Birth:/_	/_
Last	First			
Address:				
Street		City	State	Zip
Home Phone:	Cell Phone:			
Email Address:				
	Prescribing Provider Inf	ormation		
Name:				
Last Address:		First	<del></del>	
Street		City	State	Zip
Phone Number:	Email:			
State License Number:				
Device Procedure Code: <b>E1399</b>				
Medical Necessity (circle one): AN	XIETY / DEPRESSION / INS	OMNIA		
Dispense as written				
Signature of Healthcare Provider				

Return completed form via fax:

706.650.2160