Detailed Physician's/Doctor's Referral Massage Therapy

Completion by your Doctor REQUIRED to Bill Insurance for Massage Therapy

Patient Name: _____ Date of Birth: _____
Address: _____
Billing Address: _____
SS#_____ Insurance: _____ Policy #:_____

Injury Date: _____ Claim #:_____ Condition is related to: ___MVA
___Work injury / ___Stress / ____Other injury / ___ Other medical condition

Diagnosis/ICD-10 code(s): (please SPECIFY **ALL** that apply)

Head/Jaw: _____

Neck: _____

Back/Ribs/Chest: _____

Shoulder/Arms/Legs: _____

Hips/Pelvis/Sacrum/Core: _____

ANS/PNS/Emotional/Mental/Other:_____:_____

Mark:

Session Length: ___ 60 Min / ___90 Min / ___120 Min

Session Duration: __2-3x per week / __Weekly / __ Bi / __Tri Weekly / __ Monthly

Treatment Length: ___ 1-3 Months / ___3-6 Months /
___6-9 Months / ___ 9-12 Months
Patient Follow up: ___ Patient discretion / End of TX / Specific Date:_____

Physicians Name printed_____ Date: _____

Physicians Signature:__ _____

Address_____

Phone_____Fax:_____