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MESSAGE PRESCRIPTION FORM

Prescribing Provider: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

For Patient: _____ Date of Birth: _____

Note: for insurance coverage, ALL sections must be completed and clearly legible.

Start Date of Treatment: _____ Total Number of Visits: _____

(Note: insurance companies accept retroactive referrals, so the start date of treatment should be the date the patient receives the first treatment.)

Frequency: 1 / week 2 / week 3 / week 1 / month 2 / month other: _____

TREATMENT IS MEDICALLY NECESSARY for the below Diagnosis/Condition(s):

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

Prescriber's Signature: _____ Date: _____

Note: for insurance coverage, ALL sections must be completed and clearly legible.

Please return form to patient, or to Massage Doctor via fax at 866-305-5149.