PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE: _____/_____/_____

PATIENT:_____

PHYSICIAN: _____ **ADDRESS:** _____

PHONE: _____ **FAX**: _____

REFERRED TO:

Expert Medical Massage NPI:1619257607
8500 W Bowles Ave. #315, Littleton, CO 80123
Phone 1-855-323-8837 (toll free)
Fax 1-855-323-8837 (toll free)
Online Scheduling www.ExpertMedicalMassage.com (Book Now Button)

Any of the following Physicians' *Current Procedural Terminology,* CPT™ procedures and / or modalities, which are within this therapists' scope of practice, training, & / or State & / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session.

Normally four units are allowed per visit. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

97010 HOT/COLD PACKS (as necessary)
97039 UNLISTED MODALITY, by report
97139 UNLISTED PROCEDURE, by report
97124 MASSAGE THERAPY
97140 MANUAL THERAPY TECHNIQUES
97799 Unlisted Physical Medicine Rehab …… Service or Procedure (By Report)
_____ OTHER _____

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10 Code 1_____
ICD-10 Code 2 _____
ICd-10 Code 3 _____
Other _____

Times Per Week: _____ for _____ Weeks, OR Times Per Month: _____ for _____Months, or Total Visits This Script _____

Patient to return or call, prior to renewal of prescription

PHYSICIAN'S SIGNATURE: _____ **NPI #:** _____

PLAN OF CARE / COMMENTS:

_____