Valley Massage Therapy

Massage Therapy Prescription

TO Theodore M. Schiff

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01 Referring physician and patient

Referring physician

Patient name

Date

Physician address

Physician phone

Physician fax

Physician cell

02 Medical necessity and requested treatment

Treatment is medically necessary.

Please treat the diagnoses below using the selected modalities within your scope of practice.

Modalities / procedures

- ☐ **99204** Initial evaluation (45 minutes)
- ☐ **99205** Initial evaluation (1 hour)
- ☐ **97124** Massage therapy
- ☐ **97140** Manual therapy
- ☐ **97112** Neuromuscular re-education
- ☐ **97110** Therapeutic exercises
- ☐ **97010** Hot or cold packs

Condition related to

- ☐ Auto accident
- ☐ Work injury
- ☐ Illness
- ☐ Other

03 Diagnoses

- ☐ **G56.00** Carpal tunnel syndrome
- ☐ **M54.2** Cervicalgia
- ☐ **M54.10** Brachial neuritis / radiculitis (upper extremities)
- ☐ **M54.3** Sciatica
- ☐ **M54.17** Lumbosacral radiculopathy
- ☐ **M79.9** Fibromyalgia
- ☐ **R51** Headache
- ☐ **M53.3** Sacroiliac joint pain
- ☐ **M54.6** Thoracic pain
- ☐ **M19.90** Osteoarthritis
- ☐ **M70.60** Unspecified trochanteric bursitis
- ☐ **M25.559** Unspecified hip pain
- ☐ **M75.41** Shoulder impingement
- ☐ **M75.01** Capsulitis of right shoulder
- ☐ **M75.02** Capsulitis of left shoulder

Other diagnosis codes

Codes transcribed from the original form. Verify code and description before billing.

04 Treatment plan and reporting

Times per week

Number of weeks

Total treatments

Other duration or frequency

Treatment goals

- ☐ Decrease pain
- ☐ Decrease inflammation
- ☐ Decrease tension / spasms
- ☐ Increase mobility
- ☐ Other

Education to provide

	Yes	No
Self-care education	○	○
Exercise education	○	○
Ergonomic education	○	○

Send report ☐ After initial visit ☐ At end of prescription ☐ Other

05 Physician authorization

Physician signature

Signature date

Physician NPI

Physician UPIN