

INSTRUCTIONS

PLEASE take the enclosed prescription form to your Doctor and have them fill out the PHYSICIAN'S DIAGNOSIS SECTION IN THE MIDDLE,

INCLUDING THE DIAGNOSIS CODES, HOW MY VISITS PER WEEK, AND HOW MANY WEEKS THE TREATMENT IS TOO LAST.

HAVE THE DR. SIGN THE FORM AND PUT HIS/HER NPI NUMBER AND MEDICAL LICENSE NUMBER ON THE SCRIPT.

PLEASE REVIEW THE FORM AND HAVE EVERY BLANK FILLED OUT AT THE TOP AND BOTTOM.

.....
Please also include any PAPER reports from MRI, Cat Scans, or x-rays paper reports only.
.....

Our name is:

Youneedmassage.com MM11690

12909 N. 56th Street

STE 105

Tampa, FL 33617

813-989-0861

FAX: 813-464-7645
.....

Bring all this information along with your insurance PIP card, drivers License, and phone numbers and addresses to PIP, Insurance companies, Doctors, and lawyers.

Thank you.

PREScription FOR MASSAGE SERVICES

" THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY "

DATE: ____/____/____

PATIENT: _____

PHYSICIAN: _____ ADDRESS: _____

PHONE: _____ FAX: _____

REFERRED TO: **Youneedmassage.com MM11690**
12909 N. 56th Street, STE 105, Tampa, FL 33617
Phone: 813-989-0861 Fax: 813-464-7645
Web: www.massageandgifts.com

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. All procedural codes are checked for the massage Therapist. The physician can draw a line through any procedure that the physician does not want to prescribe.

PROCEDURES and MODALITIES ARE ALL AVAILABLE FOR THERAPIST

- | | |
|---|---|
| 97010 <input checked="" type="checkbox"/> HOT/COLD PACKS (as necessary) | 97124 <input type="checkbox"/> MASSAGE THERAPY |
| 97014 <input checked="" type="checkbox"/> ELECTRIC STIMULATION, un-attended | 97139 <input type="checkbox"/> UNLISTED PROCEDURE, by report |
| 97018 <input type="checkbox"/> PARAFFIN BATH | 97140 <input checked="" type="checkbox"/> MANUAL THERAPY TECHNIQUES |
| 97026 <input type="checkbox"/> INFRA-RED | 97799 <input type="checkbox"/> Unlisted Physical Medicine Rehab |
| 97032 <input checked="" type="checkbox"/> ELECTRICAL STIMULATION, attended | Service or Procedure (By Report) |
| 97035 <input checked="" type="checkbox"/> THERAPEUTIC ULTRASOUND | _____ <input type="checkbox"/> OTHER _____ |
| 97039 <input type="checkbox"/> UNLISTED MODALITY, by report | |

PHYSICIAN'S DIAGNOSIS CODE (S) OF PATIENT (Physician: Please put the Diagnosis code, times per week, how many weeks, and any comments below)

- | | |
|--|---|
| 346. <input type="checkbox"/> MIGRAINES | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |
| 784.0 <input type="checkbox"/> HEADACHES | 846.9 <input type="checkbox"/> SACROILIAC REGION (unspecified site) Spr/Str |
| 847.0 <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain | 847.3 <input type="checkbox"/> SACRUM Sprain / Strain |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain /Strain R__ L__ | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R__ L__ |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in neck) | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R__ L__ |
| 840.3 <input type="checkbox"/> INFRASPINATUS Sprain / Strain R__ L__ | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain R__ L__ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain /Strain (muscle) R__ L__ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R__ L__ |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) R__ L__ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R__ L__ |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R__ L__ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R__ L__ | 728.85 <input type="checkbox"/> SPASM OF MUSCLE |
| 842.00 <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) R__ L__ | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis) |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME R__ L__ | 728.9 <input type="checkbox"/> Unspecified Disorder Of Muscle, Ligament, Fascia |
| 842.10 <input type="checkbox"/> HAND Sprain / Strain (unspecified site) R__ L__ | |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE | Other DX <input type="checkbox"/> _____ |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain | |
| 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain | CODE (s) |
| 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain | |

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

PLAN OF CARE / COMMENTS FOR PATIENT BY PHYSICIAN:

PHYSICIAN'S SIGNATURE: _____ NPI NUMBER: _____ MEDICAL LICENSE: _____