**PRESCRIPTION / LETTER OF REFERRAL**

## “THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY”

#### DATE  \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**PATIENT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRED TO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* **Phone** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**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 procedure units & 2 max modalities allowed per visit. A Unit = 15 - minutes. Conditions or prescription may require more units.**

# **PROCEDURES and MODALITIES**

97010 ☐ HOT/COLD PACKS (as necessary)

97014 ☐ ELECTRIC STIMULATION, un-attended

97018 ☐ PARAFFIN BATH

97022 ☐ WHIRLPOOL

97026 ☐ INFRARED

97032 ☐ ELECTRICAL STIMULATION, attended

97034 ☐ CONTRAST BATHS

97035 ☐ ULTRASOUND

97036 ☐ HYDROTHERAPY (full immersion)

97039 ☐ UNLISTED MODALITY, by report

97124 ☐ MASSAGE THERAPY

97139 ☐ UNLISTED PROCEDURE, by report

97140 ☐ MANUAL THERAPY TECHNIQUES

97799 ☐ Unlisted Physical Medicine Rehab …… Service or Procedure (By Report) (Initial or Re Assessment

\_\_\_\_\_ ☐ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **PHYSICIAN’S ICD- 10 DIAGNOSIS OF PATIENT**

\_\_\_\_\_\_\_☐ MIGRAINES

\_\_\_\_\_\_\_☐ HEADACHES

\_\_\_\_\_\_\_☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain

\_\_\_\_\_\_\_☐ JAW (TMJ & Ligament) Sprain /Strain R \_\_\_ L\_\_\_\_

\_\_\_\_\_\_\_ ☐ CERVICALGIA (pain in neck)

\_\_\_\_\_\_\_☐ INFRASPINATUS Sprain / Strain R\_\_\_\_\_L \_\_\_\_\_

\_\_\_\_\_\_\_☐ SUBSCAPULARIS Sprain /Strain (muscle) R\_ \_\_ L \_\_\_\_\_\_

\_\_\_\_\_\_\_☐ SUPRASPINATUS Sprain/ Strain (muscle) R\_ \_\_ L \_\_\_\_\_\_

\_\_\_\_\_\_\_☐ SHOULDER & ARM (unspecified site) R \_\_\_ L\_\_\_\_\_\_

\_\_\_\_\_\_\_☐ ELBOW & FOREARM (unspecified site) R \_\_\_ L \_\_\_\_\_

\_\_\_\_\_\_\_ ☐ WRIST Sprain / Strain (unspecified site) R \_\_\_ L \_\_\_\_\_

\_\_\_\_\_\_ ☐ CARPAL TUNNEL SYNDROME R \_\_\_ L \_\_\_\_\_

\_\_\_\_\_\_\_ ☐ HAND Sprain / Strain (unspecified site) R \_\_\_\_ L \_\_\_\_\_

\_\_\_\_\_\_\_ ☐ PAIN IN THORACIC SPINE

\_\_\_\_\_\_ ☐ THORACIC (DORSAL) Sprain / Strain

\_\_\_\_\_\_\_☐ LUMBAR Sprain / Strain

\_\_\_\_\_\_\_ ☐ PELVIS (unspecified site) Sprain / Strain

\_\_\_\_\_\_\_ ☐ HIP & THIGH (unspecified site)

\_\_\_\_\_\_\_ ☐ SACROILIAC REGION (unspecified site) Spr/Str

\_\_\_\_\_\_\_ ☐ SACRUM Sprain / Strain

\_\_\_\_\_\_\_ ☐ LUMBOSACRAL RADICULITIS R \_ L\_

\_\_\_\_\_\_\_ ☐ SCIATICA (neuralgia, neuritis) R \_ L \_

\_\_\_\_\_\_\_ ☐ KNEE OR LEG Sprain/Strain R \_ L \_

\_\_\_\_\_\_\_ ☐ ANKLE (unspecified site) Sprain/Strain R \_ L \_

\_\_\_\_\_\_ \_☐ FOOT (unspecified site) Sprain/Strain R \_ L \_

\_\_\_\_\_\_\_ ☐ MYOFIBROSIS; muscles, ligament, fascia

\_\_\_\_\_\_ \_☐ SPASM OF MUSCLE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ ☐ MYALGIA & MYOSITIS (Fibromyositis)

\_\_\_\_\_\_\_ ☐ Unspecified Disorder of Muscle, Ligament, Fascia

\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:

**PHYSICIAN'S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor Referral Letter**

DATE:

RE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Doctor,

Your patient has chosen to utilize our services for manual therapy and/or massage therapy and requests all charges to be reimbursed from his/her insurance. In order to meet insurance and legal requirements for medically necessary care, **we need the enclosed physician’s prescription properly completed and signed**. We have pre-marked the physical medicine modalities and procedures that are within our scope of practice.

If the marked modalities and/or procedures meet your approval, please indicate the diagnoses that you would have us treat your patient’s condition**. Once completed and signed, please email back this prescription at your earliest convenience.**

It is our policy that all treating therapist are competent in advanced therapies and licensed. We will ensure that all medical documentation and progress notes of treatment will be kept current and available upon your request.

Thank you for your time and trust in our therapeutic services for your patient needs.

Sincerely,

Zen Den Healing Studio Team

Enclosure: Prescription of Medical Necessity