Self Endearment Therapeutic Massage

Physicians Referral/Prescription for Massage Therapy Services

Prescribing Physician: _____

Prescribing Physician's NPI: _____

Patient Name: _____

Address: _____City: _____State: ____Zip:_____

Work Phone:_____ Cell Phone: _____

Date of Birth: _____

Insurance Company: _____

Policy Number: _____Claim Number: _____

Billing Address: _____

Date of Injury: _____

Diagnosis/ICD-10 code(s) _____

Condition is related to:____ MVA _____ Work Injury _____ Other Injury ____ Other Medical

Number of Sessions to be performed (frequency and duration) _____

_____

Send progress report: ___ every week ___every two weeks ___at completion ____other

Special directions/comments: _____

_____

_____

Physician Signature: _____ Date: _____

Physicians Name printed: _____

Address: _____

Phone: _____Fax: _____ Email:_____