PMB PROACTIVE MASSAGE+BODYWORK

Massage Therapy Prescription / Letter of Medical Necessity

Regarding Patient: ______________________ Patient DOB: ____________

Address: ____

Phone: ______________________ Email: ______________________

Treatment is medically necessary. Please treat the patient at Proactive M+B for the diagnoses listed below using the modalities/procedures marked below that are within your scope of practice.

Medical Condition: ____

Duration and Frequency of Treatment: If a chronic condition, such as multiple sclerosis, is indicated, please list "lifetime" as the duration of treatment.

60-minute treatment at ____________ time(s) per week for ____________ weeks

Modalities/Procedures (CPT)

97124 Massage Therapy

97140 Manual Therapy, Including Lymphatic and PTSD Treatments

97110 Therapeutic Stretching

Treatment Goals

- ☐ Decrease Pain ____
- ☐ Decrease Inflammation ____
- ☐ Decrease Muscle Tension / Spasms ____
- ☐ Increase Mobility / Range of Motion ____
- ☐ Other Instructions ____

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Referring Physician: ____

Address: ____

Phone: ______________________ Email: ______________________

______________________ ______________________

Physician Signature Date