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 Exercises/Stretching

**Treatment Goals**

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

_____

_____

Referring Physician: _____

Address: _____

Phone: _____ Email: _____

_____ _____

Physician Signature Date

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