PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY #5a

FROM DOCTOR: DATE:
PHONE: FAX:

TO THERAPIST: **A BETTER WAY MASSAGE, LLC**
PH: 360-366-4216 FAX 360-778-1362

LOCATION AT 12 BELLWETHER WAY
SUITE 201, BELLINGHAM, WA 98225

REGARDING PATIENT _____, TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice.

MODALITIES / PROCEDURES

PATIENT ID:_____

PATIENT PHONE #: _____

97124/97140____ MANUAL MASSAGE THERAPY TECHNIQUES
____ ACUPUNCTURE

DX CODES

- ☐ M54.2 CERVILALGIA
- ☐ M54.5 LUMBAGO
- ☐ M54.6 THORACIC SPINE PAIN
- ☐ M25.552 LEFT HIP PAIN
- ☐ M25.551 RIGHT HIP PAIN
- ☐ M25.512 LEFT SHOULDER PAIN
- ☐ M25.511 RIGHT SHOULDER PAIN
- ☐ R51 HEADACHE
- ☐ M25.522 LEFT ELBOW PAIN
- ☐ M25.521 RIGHT ELBOW PAIN
- ☐ M25.572 LEFT FOOT ANKLE AND JOINT PAIN
- ☐ M25.573 RIGHT FOOT ANKLE AND JOINT PAIN
- ☐ M25.532 LEFT WRIST PAIN
- ☐ M25.531 RIGHT WRIST PAIN
- ☐ M79.645 LEFT FINGER(S) PAIN
- ☐ M79.644 RIGHT FINGER(S) PAIN
- ☐ M25.562 LEFT KNEE PAIN
- ☐ M25.561 RIGHT KNEE PAIN
- ☐ M79.7 FIBROMYALGIA
- ☐ M79.1 MYALGIA

OTHER DX CODES
1._____
2._____
3._____
4._____

Treatment Plan:
#_____ Massages/Week for #_____Weeks

PHYSICIAN'S SIGNATURE_____

Referring Physician NPI# Required: _____

 # OF VISITS_____ **START DATE:** _____

THIS PRESCRIPTION/REFERRAL MAY BE FAXED TO MEDICAL RECORDS: 360-778-1362

11/29/2017