KEYSTONE MEDICAL MASSAGE LLC

VERONIQUE M. BISH, LMT / 42 WEST MARKET ST BLAIRSVILLE, PA 15717 / 724.675.8825

Date _____

Regarding Patient _____

To whom it may concern,

The patient has selected our therapeutic massage services and would like the costs to be billed directly to their auto and/or workman's comp insurance provider. In order to meet insurance and legal requirements for medical necessary care, we need the enclosed physician's prescription properly completed and signed. We have pre-marked the physical medicine modalities that are within our scope of practice. If the marked modalities and /or procedures meet your approval, please indicate the diagnosis that you would have us treat for your approval, once completed and signed, please be so kind to email or mail back this prescription at your earliest convenience. It is our policy that all treatment therapists are competent in advanced therapies and duly 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.

Yours in good health,

Veronique M. Bish

Owner & LMT of Keystone Medical Massage llc

25 Years Experience

Enclosed: Physicians Prescription of Medical Necessity

KEYSTONE MEDICAL MASSAGE LLC

KEYSTONEMEDICALMASSAGE@GMAIL.COM / 42 WEST MARKET ST BLAIRSVILLE PA 15717 / 724.675.8825

Physician's Prescription/Referral/Medical Necessity

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnosis indicated below, using modalities / procedures check marked below that are within the scope of practice.

Modalities/Procedures

97124____Therapuetic Massage 97140____Manual Therapy Tech 97250____Myofascial Release

Diagnosis Codes General

307.81___Cephalgia/Tension

346.0 ____Cephalgia/Migraine

354.0 ____Carpel Tunnel Syndrome

524.60____TMJ

723.1 ____Cervicalgia

724.3 ____Sciatica

723.4 ____Upper Extremities: Brachial Neuritis/Radiculitis

784.0 ____Headache

724.4 ___Lumbosacral: Thoracic Neuritis/Radiculitis

840.0 ____Sprain Shoulder

729.1 ____Fibromyalgia/Myalgia/Myositis

846.0 ____Lumbosacral sprain/strain

840.9 ____Shoulders-upper arm sprain/strain

847.0 ____Cervical Sprain/Strain

847.1 ____Thoracic Strain/Sprain

847.2 ____Lumbar Strain/Sprain

847.3 ____Sacral Sprain/Strain

847.4 ___Coccyx Sprain/Strain

How did the injury occur:

_____

_____

_____

_____

Patient Name: _____

DOB: _____ Date of Injury: _____

Claim Type: o Auto o Workers' Comp o Other _____

Referring Physician: _____

Practice Name: _____

Phone: _____ Email _____ NPI: _____

Medical Necessity: Therapeutic massage is medically necessary for this patient.

Authorized Modalities:

o 97124 Therapeutic Massage o 97140 Manual Therapy o Myofascial Release

Treatment Frequency:

o 1x/week o 2x/week o Other _____ o Total Visits: _____

Diagnosis (ICD-10): _____

Treatment Goals:

o Pain Reduction o Increased ROM o Improved Function o Injury Recovery

Prognosis: o Excellent o Good o Fair o Guarded

Physician Signature: _____ Date: _____