Primary Care Provider's Prescription/Referral/Medical Necessity

From: _____ Phone (_____)_____

License #_____ NPI #_____

Address:_____

_____

Re Patient:_____ Date of Birth:_____

Duration and Frequency of Treatment

_____times per week for _____ weeks OR _____treatments

Head/Neck	**Extremities**	S73.119A Iliofemoral Sprain
G44209 Headaches, tension	G56.00 Carpal Tunnel Syndrome	S73.199A Hamstring Sprain
M26.69 TMJ Disorders	M25.519 Shoulder Pain	S96.919A Ankle/Foot Strain
M43.6 Neck Stiffness	M25.529 Elbow Pain	
M54.12 Radiculopathy	M25.539 Wrist Pain	**General**
M54.2 Cervicalgia (Neck Pain)	M25.559 Hip Pain	M19.90 Osteoarthritis
R51 Headache	M25.569 Knee Pain	M12.9 Arthritis NOS
S13.101A Cervical Subluxation	M25.579 Leg/Foot Pain	M25.50 Joint Pain-Multi
S13.8XXA Cervical Sprain	M25.669 Knee Stiffness	M25.60 Joint Stiffness
	M25.729 Elbow Tendonitis	M62.838 Muscle Spasm
Thoracic	M54.30 Sciatica	M72.9 Fasciitis NOS
G54.0 Thoracic Outlet Syndrome	M75.00 Frozen Shoulder	R25.2 Muscle Cramp
M54.16 Lumbar Radiculopathy	M75.100 Should Bursitis	R53.83 Fatigue
M54.50 Low Back Pain	S33.6XXA Sacroiliac Sprain	T14.90 Unspecified Injury
M54.6 Thoracic Pain	S33.8XXA Lumbosacral Sprain	
M54.9 Unspecified Back Pain	S46.819A Sprain-Shoulder	**Other DX Codes**
S23.3XXA Thoracic Sprain	S46.919A Shoulder/Upper Arm	1._____
	S50.919A Forearm injury	2._____
	S66.919A Wrist Strain	3._____
	S69.90XA Wrist injury	4._____

To: Areigna M. Preston, OMT, LMT, BCTMB
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Email: areigna@pwtherapies.com

Massage has been proven to be an effective complementary treatment as an assistant in the relief and management of pain.

To schedule your massage call Profound Wellness, LLC at (470) 323-7665

4855 River Green Pkwy, Ste 610◇Duluth, GA 30096

CPT Code 97140 MANUAL THERAPY TECHNIQUES

List ICD-10 Code(s):_____

_____

_____

Reporting: □Send Report □After 1st visit □End of Rx Fax report to: (_____)_____

As the authorized primary care physician, I have determined that **treatment is medically necessary.** Please treat the patient for the above indicated diagnoses, using the modalities and procedures marked and within your scope of practice

Authorized Doctor Signature:_____ Date Issued:_____ Expiration Date: _____

Comments: _____

_____