# Physician's Prescription of Medical Necessity

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**Physician's Prescription of Medical Necessity**

Patient Name: _____

DOB: _____ Insurance: _____

Phone Number: _____

Ordering Physician: _____

Diagnosis: _____

_____

Date of Injury:_____ # of Visits:_____ # Per week:_____

**Evaluate and Treat as Appropriate: _____ 97010 Hot or Cold Pack**

**___ 97410 Manual Therapy Techniques ____ 97124 Massage Therapy**

**___ 97530 Therapeutic Activity ____ 97110 Therapeutic Exercise (AROM) (ROM)**

___ Brachial Neuritis/Radiculitis (upper extremities)

___ Carpal Tunnel ___ Cervicalgia ___ Cervical Sprain/Strain

___ Fibromyalgia/Myalgia/Myositis ___ Foot Sprain/Strain R__ / L __

___ Knee or Leg Sprain/Strain R__ /L__ ___ Lumbar Sprain/Strain

___ Migraine ___ Sciatica ___ Sacral Sprain/Strain ___**TMJ**

___ Shoulder Sprain/Strain R__ / L__ ___ Thoracic Sprain/Strain

Special Note: _____

Dr. Signature: _____ Date: _____

NPI#: _____ License#: _____