Referral Form for Massage Therapy

Please Select:

- ○ Worker's Compensation
- ○ No Fault/MVA

Patient's Information:

Last Name:_____First Name:_____

Patient Phone: _____ DOB:____/____/_____

Patient Address: _____

Primary Insurance: _____Subscriber Number:_____

Secondary Insurance: _____Subscriber Number:_____

Diagnosis (ICD-10)/Reason for Referral:_____

Frequency (x per week): 1 2 3 4 5 Duration (in weeks): 2 3 4 6 8 10 12

Referral start date:_____ Referral end date:_____ Other:_____

Special Instructions:

Authorization:

Referring Physician:_____Ph:_____Fax:_____

Referring Signature:_____Date:_____/_____/_____

For office use only: **Worker's compensation/No Fault MVA Information Only**

Approved by (Adjuster Name):_____Claim #_____Adjuster Signature:_____

Employer:_____Start Date:_____End Date:_____Date Approved:_____

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