BIC
Medical Massage + Rehabilitative Manual Therapy
BodyinContext.com Ph:541.210.5999
314 E. Main, Talent OR, 97540 Fax:541.210.8725

Physician's Prescription:

Referring Physician _____

Email: _____ NPI # _____

Phone: _____ Fax: _____

Regarding Patient _____ **Treatment is Medically Necessary.** Please treat the patient for the diagnoses indicated below, using modalities/procedures within your scope of practice.

Patient: _____

Phone: _____ DOB: ____/____/____

ICD 10 Codes

_____

_____

_____

_____

_____

(For manual therapy prescription ICD-10 codes must reflect soft tissue pathologies)

Additional Comments: _____

_____

_____

_____

REQUIRED

Frequency: _____ times/week for _____ weeks

This prescription is an **evaluate and treat order** unless specifically written above.

I certify the above Treatment Plan is medically necessary & approved.

Physician's Signature _____ Date: _____

(Form must be filled out and signed by Doctor in order for you to receive treatment)