Massage Doctor

Dr. Abdul Karim Taifour, LMPC
Phone 206-226-2527, Fax 866-305-5149
P.O. Box 27612, Seattle WA 98165
www.massagedoctor.com

MASSAGE PRESCRIPTION FORM

For Patient: _____ Date of Birth: _____

Prescribing Provider: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Note: for insurance coverage, ALL sections must be completed and clearly legible.

Start Date of Treatment: _____ Total Number of Visits: _____

(Note: insurance companies accept retroactive referrals, so the start date of treatment should be the date the patient receives the first treatment.)

Date of accident/injury: _____

Frequency: 1 / week 2 / week 3 / week 1 / month 2 / month other: _____

TREATMENT IS MEDICALLY NECESSARY for the below Diagnosis/Condition(s):

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

ICD Code: _____ Condition: _____

Prescriber's Signature: _____ Date: _____

Note: for insurance coverage, ALL sections must be completed and clearly legible.
Please return form to patient, or to Massage Doctor via fax at 866-305-5149.