Wholistic Massage LLC

Physician/Provider Prescription/Referral Form

From Provider/Clinic Name: ____

Patient Name: (Please print below)

____

Patient's Phone Number: __________________________

Date of Birth: ________________ Insurance ID#: ___________________________

Claim Number: __________________ Date of Injury/Illness: ________________

Please treat this patient for the diagnosis listed below, using modalities and procedures within your scope of practice. This treatment is medically necessary for the health of this patient.

Referred to: Wholistic Massage and Wellness LLC
Elizabeth Pearch, BA, ACMT, LMT NPI#1023328507 State of AK Lic# 101210

IDC 10 Diagnosis codes: ____

# of treatments: _______ # of times per week: ________ for # weeks________
Description of condition:

Possible precautions due to condition:

Possible interactions with medications:

Referring Provider's Name: (please print below)

____

Phone: ______________________________ FAX: ___________________________

Provider's NPI#: ______________________________________Date: ___________

Provider's signature: ____

Do you want a clinical report from us in 60 days? NO YES

Wholistic Massage LLC | 700 W 58th Ave., Unit A, Anchorage, AK 99518 | 907-312-9578
Fax (888) 316-4387