



Referral Form for Massage Therapy

Please Select:

☐ **Worker's Compensation**

☐ **No Fault/MVA**

Patient's Information:

Last Name: _____ First Name: _____

Patient Phone: _____ DOB: ____/____/____ E-Mail: _____

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: ____/____/____ NPI#: _____

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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