SOUTHWEST THERAPY AND REHABILITAION
PHYSICIAN'S PRESCRIPTION
FAX 505-896-2958

ARIZONA
Phone 505-239-9644

Physician's Prescription of Medical Necessity

Referring Physician: _____

Phone:_____ Fax#: _____

NPI# _____ Dr. Address: _____

UPIN#_____

Regarding Patient:_____DOB_____,
TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indication below, using the modalities/procedures check marked below that are within your scope of practice.

MODALITIES/PROCEDURE

97140___ Manual Therapy Techniques

DX CODES
354.0___Carpal Tunnel Syndrome
723.1___Cervicalgia
723.4___Brachial Neuritis/Radiculitis (UE)
724.3___Sciatica
724.4___Lumbosacral/Thoracic Neuritis or Radiculitis (LE)
729.1___Fibromyalgia/Myalgia/Myositis
784.0___Headache
840.9___Shoulders-Upper Arms Strain/Sprain
846.0___Lumbosacral Strain/Sprain
847.0___Cervical Strain/Sprain
847.1___Thoracic Strain/Sprain
847.2___Lumbar Strain/Sprain
847.3___Sacral Strain/Sprain
847.4___Coccyx Strain/Sprain
848.1___T.M.J. Strain/Sprain
Other Dx Codes: 1._____2._____

Of Visits_____ # Of Times Per Week_____ # Of Weeks_____

Special Notes _____
_____

Dr. Signature_____ Date:_____