

SOUTHWEST THERAPY AND REHABILITATION

PHYSICIAN'S PRESCRIPTION

FAX 505-896-2958

CHANDLER AND OCOTILLO AZ

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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: _____