

# Medical Billing, Collection and Consultation

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## Treatment for Massage Therapy

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ (Please add DX codes)

Areas concerned;     Cervical                       Thoracic  
                                  Shoulder                       Lumbar/lumbosacral

Precautions:

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This condition is related to:     auto accident             work injury             general medical

Other: \_\_\_\_\_

### TREATMENT PLAN:

Rx frequency: 1x/wk 2x/wk 3x/wk 1x/2wks for \_\_\_\_\_ weeks.

- Massage
- Hot/cold packs
- Manual traction

### TREATMENT GOALS:

- |                                            |                                                    |                                            |
|--------------------------------------------|----------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Increase ROM      | <input type="checkbox"/> Decrease pain             | <input type="checkbox"/> Restore posture   |
| <input type="checkbox"/> Increase strength | <input type="checkbox"/> Decrease edema            | <input type="checkbox"/> Restore function  |
| <input type="checkbox"/> Increase mobility | <input type="checkbox"/> Decrease muscle tightness | <input type="checkbox"/> Patient education |

Additional comments:

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Physician's signature:

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Signature

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Printed Name

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# PATIENT PRIVATE HEALTH INSURANCE VERIFICATION FORM

Does your Ins. Policy cover Massage Therapy performed by an LMP?  Yes  No

Does treatment have to be referred?  Yes  No

Does treatment have to be prescribed?  Yes  No

Who can refer/prescribe Massage Therapy? :  PCP  MD  DC  ND

Who is the Primary Care Physician (PCP) ? \_\_\_\_\_ Phone# \_\_\_\_\_

Does the plan require **pre-authorization**?  Yes  No

Who is responsible for pre-authorization?  The Doctor  The Massage therapist

What is the address, phone#, fax# authorization and reports should be sent to?  
\_\_\_\_\_  
\_\_\_\_\_

What is the annual Massage benefit limits? \_\_\_\_\_  
(\$ amount and/or # of treatments)

Do the benefit limits include treatment by a P.T. and/or a D.C.?  Yes  No

What is the deductible? \_\_\_\_\_ has it been met?  Yes  No  
if No, remaining amount \_\_\_\_\_

Is there a co-pay?  Yes If yes, how much? \_\_\_\_\_  No

Does the LMP have to be a Preferred Provider?  Yes  No

Is \_\_\_\_\_ LMP on the list?  Yes  No

Are there "out of network" benefits?  Yes  No  
if yes, what % \_\_\_\_\_

is the deductible the same?  Yes  No

if no, Amount \_\_\_\_\_  
is the annual Massage benefit limit the same  Yes  No

Where should claims be sent? \_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Person you spoke with \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

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- Increase mobility                       Decrease muscle tightness                       Patient education

Additional comments:

\_\_\_\_\_  
\_\_\_\_\_

Physician's signature:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

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