Therapeutic Massage Prescription/Order

Authorizing Prescriber:_____

Office Address:_____

Phone Number:_____

Patient Name:_____ **DOB:_____**

Address:_____

Therapeutic Massage

Unlimited Sessions as needed for

-Stress Z73.3

-Chronic Pain G89.4

-Myalgia M79.1

-Joint Pain M25.50

-_____

-_____

Please circle all that apply or add additional diagnosis

Authorizing Providers Signature:_____ **Date:_____**

This order is good for one year from date written.

This will be used for HSA/FSA reimbursement purposes.