APPALACHIAN MEDICAL MASSAGE ASSOCIATES

We work *with* you, not *on* you.

Thank you for the opportunity to help you in the process of caring for your patients. In order to facilitate this process, we need some information from your office

Attached is a copy of our Prescription / Referral / Letter of Medical Necessity. Please indicate the treatment plan and diagnoses that you would have us treat and then sign and fax back at your earliest convenience.

It is extremely important that the form is filled out in its entirety. Not doing so may result in unnecessary delays for the patient. We are held to a different standard than other licensed medical health care providers and must have the all of this information in order to obtain preapproval and file with insurance.

Please refer to the following checklist before faxing:

- ☐ Did you fill in all the blanks in the top section, including Physician's Name, Date, Phone & Fax Numbers, and the Patient's Name?
- ☐ Did you mark at least one Modality / Procedure to include in the treatment plan?
- ☐ If this is the first time you have referred this patient, please mark 97001 to include an initial evaluation. (This is required unless your office provides us with a recent thorough evaluation of the patient by a physical therapist.)
- ☐ Did you mark at least one Diagnosis code? (The most common codes are included on the form. There is space at the right where additional codes may be written.)
- ☐ Did the physician sign the form?
- ☐ Did you enter the physician's state license number?
- ☐ Did you enter the physician's NPI number?
- ☐ Did you specify the number of visits? Number of times per week? Number of weeks? Are the number of visits equal the number of weeks multiplied by the number of times per week?
- ☐ Did you specify the interval at which physician would like to receive progress notes?
- ☐ Did you specify how the notes should be submitted? If by email, is the email address included?

Great! You are now ready to fax it to us at 423-245-7863.

We look forward to our association and your direction. Thank you!

If you have any questions or concerns, feel free to give us a call at 423-288-2662 or send an email to amma@ammatn.com. You may also wish to consult our website for answers to your questions and to learn more about the services that we offer.

317 Cherokee St., Suite 101
Kingsport, TN 37660

www.ammatn.com

Phone: (423) 288-2662
Fax: (423) 245-7863

**PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY #5a**

FROM DOCTOR: _____DATE:_____

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

TO THERAPIST: Amber L. Vachon, NCMMT NPI: 1760522726 PHONE: 423-288-2662 .

ADDRESS: 317 Cherokee Street, Suite 101 – Kingsport, TN 37660 FAX: 423-245-7863 .

REGARDING PATIENT _____ TREATMENT IS MEDICALLY NECESSARY.

Please treat the patient for diagnoses indicated below, using the modalities/procedures check marked below that are within your scope of practice.

MODALITIES / PROCEDURES

97001____ EVALUATION (required for first-time patient referrals)
97002____ RE-EVALUATION
97010____ HOT OR COLD PACKS
97034____ CONTRAST BATHS
97036____ HYDROTHERAPY (ATTENDED)
97110____ THERAPEUTIC ASSISTED EXERCISE (to develop strength, endurance, range of motion and flexibility)
97112____ NEUROMUSCULAR RE-EDUCATION (to develop balance, posture, proprioception, coordination, kinesthetic sense, PNF)
97124____ MASSAGE THERAPY (stroking, compression, percussion)
97140____ MANUAL THERAPY TECHNIQUES (includes myofascial release, mobilization, manipulation, manual traction, lymphatic drainage, trigger point therapy)

DX CODES

354.0____ CARPAL TUNNEL SYNDROME
723.1____ CERVICALGIA
723.4____ UPPER EXTREMITIES: BRACHIAL NEURITIS / RADICULITIS
724.3____ SCIATICA
724.4____ LUMBOSACRAL / THORACIC NEURITIS OR RADICULITIS (Lower Extremities)
729.1____ FIBROMYALGIA / MYALGIA / MYOSITIS
784.0____ HEADACHE
840.9____ SHOULDERS-UPPER ARMS SPRAIN/STRAIN
846.0____ LUMBOSACRAL SPRAIN / STRAIN
847.0____ CERVICAL SPRAIN / STRAIN
847.1____ THORACIC SPRAIN / STRAIN
847.2____ LUMBAR SPRAIN / STRAIN
847.3____ SACRAL SPRAIN / STRAIN
847.4____ COCCYX SPRAIN / STRAIN
848.1____ T.M.J. SPRAIN / STRAIN

OTHER DX CODES
1._____
2._____
3._____
4._____

PHYSICIAN'S SIGNATURE_____

STATE LICENSE#_____ NPI#_____

**# OF VISITS_____ # OF TIMES PER WEEK_____ # OF WEEKS _____**

**PROGRESS NOTES SUBMITTED _____ WEEKLY _____ MONTHLY _____AT END OF TX**

**PLEASE SUBMIT VIA: _____ FAX _____ EMAIL: _____**

SPECIAL NOTES_____

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