# LEHP PLAN MASSAGE THERAPY ORDER /PRESCRIPTION /TREATMENT PLAN

Ordering Doctor ______________________ Date: ____________
Address: ______________________ Phone: ____________
______________________
LMT: ______________________
Address: ______________________ Phone: ____________
______________________

Regarding Patient: ______________________ ID# ______________
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.
Physicians Signature______________________ Date: ____________
License # ______________________ UPIN# ______________

***LMT: Please keep this form with your clinical records for verification of diagnosis and treatment plan. Codes 97124 and 97140 are different procedures with specific criteria. You must document medical necessity for the actual service provided along with length of service, within your clinical notes and bill appropriately.***

Modalities / Procedures
97124 ____ Massage Therapy
97140 ____ Manual Therapy Techniques
97010 ____ Hot or Cold Packs

Condition is related to:
____ Auto Accident ______________
____ Work Injury ______________
____ Illness ______________
Other ______________

Diagnosis Codes
G56.01 ____ Carpel Tunnel Syndrome
M54.12 ____ Cervicalgia
M79.2 ____ Brachial Neuritis / Radiculitis/ Strain (upper extremities)
M54.30 ____ Sciatica
M54.15 ____ Lumbosacral /Thoracic or Radiculitis (lower extremities)
M54.89 ____ Back Pain
M62.40 ____ Myospasm
M79.7 ____ Fibromyalgia / Myalgia
M79.609 ____ Arm or Leg Pain
R51 ____ Headache
S13.111A____ Subluxation Cervical Vertebrae
S23.101A____ Subluxation Thoracic Vertebrae
S33.101A____ Subluxation Lumbar Vertebrae

S33.2XXA ____ Subluxation Sacral Region
S43.409A ____ Shoulders - Upper Arms Sprain
S53.409A ____ Elbow or Forearm Sprain/Strain
S73.109A ____ Hip or Thigh Sprain/Strain
S33.8XXA ____ LumbosacralSprain/Strain
S13.4XXA ____ Cervical Sprain/Strain
S23.3XXA ____ Thoracic Sprain/Strain
S33.5XXA ____ Lumbar Sprain / Strain
S33.8XXA ____ Sacral Sprain / Strain
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Other Codes:
________ ______________
________ ______________
Treatment Goals

Duration and Frequency of Treatment

______ Times Per Week For ____ Week

# of 15 Minute Units_____ OR # Treatments ____

Other Diagnosis Codes:
1. ______________
2. ______________
3. ______________

The ordering physician completes this form. Once completed, provide it to your Licensed Massage Therapist