

Healing Touch Massage Lmt
937.533.3354
contactus@healingtouchmassagelmt.com
healingtouchmassagelmt.com
1066 Reading Rd. Mason, Ohio 45040

Doctor Referral Letter

DATE:

RE: _____

Dear Doctor,

Your patient has chosen to utilize our services for manual therapy and/or massage therapy and requests all charges to be reimbursed from his/her insurance. In order to meet insurance and legal requirements for medically necessary care, **we need the enclosed physician's prescription properly completed and signed.** We have pre-marked the physical medicine modalities and procedures that are within our scope of practice.

If the marked modalities and/or procedures meet your approval, please indicate the diagnoses that you would have us treat your patient's condition. **Once completed and signed, please email back this prescription at your earliest convenience.**

It is our policy that all treating therapist are competent in advanced therapies and licensed. We will ensure that all medical documentation and progress notes of treatment will be kept current and available upon your request.

Thank you for your time and trust in our therapeutic services for your patient needs.

Sincerely,

Enclosure: Prescription of Medical Necessity