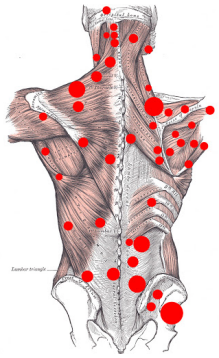

Clinical Massage Therapy

CMT Rocklin
5714 Lonetree Blvd
Rocklin, CA 95765
Office: 916.259.2510
Fax: 916.259.0073
Admin@cmtca.org

Letter Of Medical Necessity

Patient Name: _____ Date: _____

Patient Phone Number: _____ DOB: _____

A. Referring Health Care Provider (HCP)

Contact Information

HCP Name/ID # _____

NPI#_____

Address _____

City _____ State_____Zip_____

Phone _____

Fax _____

Email _____

B. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary and Secondary)

- ☐ Head_____
- ☐ Neck_____
- ☐ Chest_____
- ☐ Shoulders_____
- ☐ Abdomen_____
- ☐ Back_____
- ☐ Low back/Hips_____
- ☐ Upper extremities_____
- ☐ Lower extremities_____
- ☐ All of the above_____
- ☐ Other:_____

Treatment Type

- ☐ Manual Therapy_____
- ☐ Hot/Cold Packs_____

Frequency and Duration

- ☐ _____x a week for _____weeks
- ☐ _____x a month for _____months

Specific Instructions/Precautions: _____

_____

Please send this completed form to admin@cmtca.org or Fax Number: (916)259-0073

HPC Signature: _____ Date: _____