Date: _____
RE: Letter of Medical Necessity & Authorization for Massage Therapy

Patient Name: _____
Date of Birth: _____

To Whom It May Concern,

I am writing on behalf of my patient, _____, to confirm that massage therapy is medically necessary as part of their treatment plan.

Diagnosis/Condition(s):_____

Medical Code(s):_____

Notes:_____

_____

_____

_____

Treatment Plan Recommendation:

Type of Service: Therapeutic Massage Therapy
Provider: Angela Williams, LMT (NPI: 1326939182)
Frequency: _____ session(s) per week _____ session(s) per month
Duration: _____ minutes per session (30, 60, 90)
Length of Treatment Plan: _____ weeks/months, followed by reassessment

Massage therapy services will be provided by the above-named licensed provider and are recommended as a part of this patient's integrative care plan.

This letter serves as both medical authorization and documentation of necessity for insurance reimbursement purposes.

Please contact my office if further information is required.

Sincerely,

X_____
(Name & Contact Information)