KINGSTON TRUST FUND

Utilization Management by Hughes and Associates
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THERAPEUTIC MASSAGE

(Physician's Prescription)

Patient Name: _____	**Prescribing Physician: _____**
Insured ID#: _____	**Address: _____**
Address: _____	**City: _____**
City/State/Zip: _____	**State/Zip: _____**
Phone: _____	**Phone: _____**

DIAGNOSIS	ICD 10 Code	AUTHORIZATION REQUEST
1. _____	**_____**	**Start Date: _____**
2. _____	**_____**	**Frequency: _____**
3. _____	**_____**	**Duration: _____**

EVALUATION FINDINGS: **Date of Onset: _____**

Chief Complaints/Current Complaints: _____

_____

Mechanism of Injury/Onset: _____

Exam: _____

_____

_____

ROM: _____

_____

Radiographic Findings: (if indicated) _____

_____

Current Treatment Goals/Outcome: _____

_____

Estimated Date of Release: _____

Physician's Signature: _____ Date: _____