OHSU Massage Therapy Benefit Authorization Form

PO Box 40384
Portland, OR 97240 (503) 243-4496 (800) 258-2037 Fax (503) 243-5105

This form only applies to OHSU members seeking Massage Therapy treatment with an OHSU provider

Patient Information

Patient Name _____ DOB _____ ID # _____

Subscriber Name _____ Group # _____ Group Name _____

Specialist Information

Facility/Specialist _____

Ph# _____ Ext# _____ Fax# _____ Contact _____

Address/Location _____

Authorization Information

ICD10 Code(s) _____ _____ _____ _____

OHSU Specialist: Please check the box below if you attest to OHSU Massage Therapy benefit details

The Plan pays for services provided by an OHSU Licensed Massage Therapist. Medical necessity documentation is required after 6 visits and if it is not received prior to the 7th visit, the claim will be **denied**. This form should be faxed back to the number listed above **prior** to a member's 7th visit.

Massage therapy services are defined by services billed with the procedural code CPT 97124

☐ I attest to the following _____

A. I am an OHSU Licensed Massage Therapist
B. Services being requested are for future dates of service
C. Patient has been treated six times
D. Therapy services will be short term in nature
E. Patients condition is expected to improve with further treatment
F. Treatment being performed is not maintenance therapy

Date Span Requested _____ To _____

Scheduled Date _____

Additional Comments _____

_____