

# Massage Therapy Prescription Submission Form

Please use the provided contact information to mail or fax the completed form.  
A copy of the prescription for massage therapy service must be included.

PO Box 91059  
Seattle, WA 98111-9159  
Partner Services: 1-877-728-9020  
Fax: 1-866-447-8670  
1-509-252-7245

## Section A: Patient Information (please complete all fields)

Member/Patient name: \_\_\_\_\_

Member/Patient date of birth (mm/dd/yyyy): \_\_\_\_\_

Premera member identification number: \_\_\_\_\_

## Section B: Prescribing Provider Information

Prescribing Provider name: \_\_\_\_\_

Prescribing Provider phone number: ( ) \_\_\_\_\_

## Section C: Prescription Information

New     Updated     Copy of previously submitted

Use the space below to **attach** your prescription.

Please ensure the prescription is clearly legible to avoid it being returned.

The prescription must indicate a diagnosis (ICD-9 code), frequency of treatments, number of visits, start date and end date.

**Do not write in box.**

**Note:** Please note that this is not a pre-authorization of benefits, nor a guarantee of payments.

**Confidentiality Notice:** The information is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you have received this communication in error, please immediately notify us by telephone at 1-877-728-9020.