Compassion Massage
THERAPEUTIC CLINIC

CompassionMassage.com

FSA/HSA Medical Necessity Form

The Purpose of this form is to assist you in obtaining the necessary documentation from your healthcare provider to use your Flexible Spending Accounts(FSAs) or Health Savings Accounts(HSAs) if your benefits plan requires so.

Patient Name _____

Date _____

Diagnosis _____

Frequency of Treatment _____

Duration of Treatment _____

Specific Goals _____

Precautions _____

Additional Comments

_____

_____

_____

This prescription is an evaluate and treat order unless specified otherwise above.

I CERTIFYT THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature_____

(this must be signed by a Doctor in order for you to receive treatment)

1137 Main Street
Leominster, MA 01453
(978) 534-0101
info@compassionmassage.com