ORIGIN
Pelvic Health & Occupational Therapy

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www.originpelvichealth.com

Patient Name: _____ Date of Birth: _____

Physician/NPI#_____ Initiate date: _____

Diagnosis/ICD-10: _____

Special instructions/comments: _____

_____

☐ **Occupational Therapy Evaluate & Treat**

Statement of medical necessity: I certify that the patient listed above is under my care and that the therapy requested is medically necessary for the health of this patient.

_____ _____

Physician signature Date

FAX TO: 877-552-1413