TREATMENT PLAN TEMPLATE

Patient Name:	Start Date:

Dx/Presenting Problem:	
Code:	*Description:*
Code:	*Description:*
Dx Symptom Qualifiers	

Goals and Objectives: *Define clear, measurable goals and the steps needed to achieve them. Objectives should be specific, action-oriented, and progress should be reviewed regularly.*	
Long Term Goal 1:	
Objective 1:	*Intervention(s)*
	Duration/Frequency:

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<tr><td>Duration/Frequency:</td></tr>
<tr><td rowspan="2">Objective 3:</td><td>Intervention(s)</td></tr>
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Goals and Objectives: *Define clear, measurable goals and the steps needed to achieve them. Objectives should be specific, action-oriented, and progress should be reviewed regularly.*	
Objective 3:	*Intervention(s):*
	Duration/Frequency

Medical Necessity Checklist

1. Diagnosis & Symptoms

- ❒ *Diagnosis and symptoms align with clinical guidelines*
- ❒ *Treatment is evidence-based and medically necessary*
- ❒ *Symptoms impact function or daily living activities*
- ❒ *Alternative treatments have been considered*
- ❒ *Documentation includes rationale for interventions*

2. Clinical Justification

- ❒ *Treatment/procedure aligns with* ***evidence-based guidelines***
- ❒ *Condition* ***would likely worsen*** *without this intervention*

Medical Necessity Checklist

❒ *Non-invasive or lower-cost alternatives* ***were attempted or ruled out***

❒ *Treatment is not primarily for patient preference, convenience, or cosmetic purposes*

3. Previous Treatments & Alternatives Considered

❒ ***Conservative treatments attempted:***

❒ *Medication trials*

❒ *Lifestyle modifications*

❒ *Physical therapy*

❒ *Other (specify): _____*

❒ *Documented reason for* ***why alternatives were ineffective or inappropriate***

4. Provider's Clinical Judgment & Supporting Evidence

❒ *Medical notes document* ***necessity of intervention***

❒ *Diagnostic imaging/lab results support clinical need*

❒ *Risk-benefit assessment performed and documented*

❒ *Expected clinical outcome with treatment: _____*

5. Insurance/Payer Criteria Compliance

❒ *Meets payer-specific* ***medical necessity guidelines***

❒ *Required* ***pre-authorization obtained*** *(if applicable)*

❒ *Documentation includes:*

- ❒ *Physician's rationale*
- ❒ *Supporting test results*
- ❒ *Prior authorization reference number (if applicable)*

TREATMENT PLAN TEMPLATE

Provider Attestation		
I attest that the above treatment plan is medically necessary and aligns with clinical guidelines.		
Provider Name:	**Signature:**	**Date:**

Progress Plan: *Milestone dates for assessment, with a transition plan or alternative actions if needed.*	
*Progress will be reassessed every **[ ]** weeks, with modifications as needed.*	
Milestones:	
Plan Updates:	*Additional Notes:*