



Patient Name:	Start Date:
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<b>Dx/Presenting Problem:</b>	
Code:	Description:
Code:	Description:
<b>Dx Symptom Qualifiers</b>	

<b>Goals and Objectives:</b> <i>The primary goal is to achieve and maintain sobriety while improving overall well-being through structured interventions and relapse prevention strategies.</i>	
<b>Long Term Goal 1:</b>	
Objective 1:	Intervention(s)
	Duration/Frequency:



**Goals and Objectives:** *The primary goal is to achieve and maintain sobriety while improving overall well-being through structured interventions and relapse prevention strategies.*

*Objective 2:*

*Intervention(s)*

*Duration/Frequency:*

*Objective 3:*

*Intervention(s)*

*Duration/Frequency:*



**Goals and Objectives:** *The primary goal is to achieve and maintain sobriety while improving overall well-being through structured interventions and relapse prevention strategies.*

**Long Term Goal 2:**

*Objective 1:*

*Intervention(s)*

*Duration/Frequency:*

*Objective 2:*

*Intervention(s)*

*Duration/Frequency:*



**Goals and Objectives:** *The primary goal is to achieve and maintain sobriety while improving overall well-being through structured interventions and relapse prevention strategies.*

Objective 3:

Intervention(s):

Duration/Frequency

### Medical Necessity Checklist

#### 1. Diagnosis & Symptoms

- Diagnosis meets **DSM-5 criteria** for Substance Use Disorder
- Symptoms impair function, relationships, or safety
- Medication-Assisted Treatment (MAT) considerations documented (if applicable)
- Psychosocial interventions included (therapy, peer support, behavioral interventions)
- Relapse prevention plan incorporated

#### 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. Medications tried: \_\_\_\_\_
- Lifestyle modifications
- Social support or support group
- Family support/education
- Family support/education
- Other (specify): \_\_\_\_\_
- Documented reason for **why alternatives were ineffective or inappropriate**

### 4. Provider's Clinical Judgment & Supporting Evidence

- Medical notes document **necessity of intervention**
- 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)



<b>Provider Attestation</b>		
<i>I attest that the above treatment plan is medically necessary and aligns with clinical guidelines.</i>		
<b>Provider Name:</b>	<b>Signature:</b>	<b>Date:</b>

<b>Progress Plan:</b> <i>Milestone dates for assessment, with a transition plan or alternative actions if needed.</i>	
<i>Progress will be reassessed every [ ] weeks, with more frequent follow-ups in early recovery.</i>	
<i>Milestones:</i>	
<i>If relapse occurs:</i>	<i>Additional Notes:</i>