Medicare Medical Necessity

Required for Medicare Reimbursment

Name: _____

Date of incident: _____

Describe the incident and how it occurred:

_____

_____

_____

What daily activities are affected? (circle all that apply)

Sleeping	Eating	Walking	Lifting
Bending	Kneeling	Twisting	Carrying
Pushing/Pulling	Overhead Reaching	Climbing	Stooping

Other_____

What body regions are affected? (circle all that apply)

Muscle	Joint	Nerve	Headache
Eyes	Ears	Throat	Heart
Lungs	Abdomen	Bladder	Hormone
Skin	Other:_____		

Physician Use Only

Medicare Required Treatment Plan:

This week _____ Week 2_____ Week 3 _____ Week 4_____

Pain Level (Circle) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10