

Beneficiary Name: _____ **Medicaid#:**

Physical Therapy Evaluation Date: / / 20 **Re-evaluation Date:** / / 20

Diagnoses/Conditions being Addressed <i>(Describe specific problems requiring therapy.)</i>							
	<i>Description (e.g., Medical - CVA, Therapy - paralysis of lower limb)</i>						
Medical Diagnoses:	<table border="1"> <thead> <tr> <th colspan="2">ICD-9 Codes:</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>	ICD-9 Codes:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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History Related to Diagnosis and Therapy:

I. Date of Onset: / /

II. Recent Hospitalizations/Dates:

III. Pertinent Medical History: *[mechanism of injury, diagnostic imaging/testing, medications, co morbidities (complicating or precautionary information)]*

IV. Prior Therapy History for Same Diagnosis/Condition and Response to Therapy:

V. Social History: *(Identify primary caregiver, effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment and caregiver's ability/inability to assist with therapy)*

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VI. Level of Function: *(Initial Evaluation – record functional level prior to current condition. For Reevaluation, record the patient’s original functional level prior to institution of therapy and current functional level.)*

VII. Clinical Status/Impairments: *[Motor function, muscle tone/distribution, neuromotor development, reflex integrity, special/ standardized tests including the name, scores/results, and date administered, cognitive function, sensation/proprioception, edema, vision/hearing, posture, AROM, PROM, strength, pain, coordination, bed mobility, balance (sitting and standing), transfer ability, ambulation (level and elevated surfaces), gait analysis, assistive/adaptive devices (currently in use or required), activity, tolerance, presence of wounds (including description and incision status), assessment of the beneficiary’s ability to perform ADLs, potential for rehabilitation, age appropriate information on all children (e.g. chronological age/corrected age), motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy.]*

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VIII. Impression/Interpretation of Findings:

IX: Discharge Plan: *(including requirements to return to home, school and/or job)*

Attestation Statement: *A therapy provider who knowingly or willfully makes, or causes to be made, any false statement of representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that I am the therapy provider who performed the therapy evaluation / reevaluation on the Medicaid beneficiary listed on this form. I certify that the information provided on the Evaluation/Reevaluation Form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or disqualify me as a provider of Medicaid services.*

Signature and Title of Physical Therapist

Date

HealthSystems of Mississippi
175 E. Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201

HealthSystems of Mississippi Medicaid
Outpatient Physical Therapy
Evaluation/Reevaluation Form
Addendum Page

Beneficiary Name: _____ **Medicaid#:**

Important Notice: When entering information on the Addendum Page, please reference the appropriate section.
(For Example: II. Recent Hospitalizations/Dates: ORIF right arm on 07/01/06)