MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT
PHYSICIAN'S SIGNATURE

Name:
SSN:
DOB:

Primary Diagnosis (ICD Code – Diagnosis Description):

Diseases

Other Diagnoses

I certify that this individual requires nursing facility services or alternative community based services under supervision of an MD/DO. ☐ **YES** ☐ **NO**

X______________________ __________________

MD/DO Name:
Military Physician:
MD/DO License #:
MD/DO License State:

Date