Treatment Plan Calculator

Name: _____ _____ ***D.O.B.*** _____

Option # ___	Title: _____			Total Annual Deductible			
Projected Length of Time: _____				Ins. Coverage $ _____			
DOCTOR VISITS	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
MEDICATION	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
DIAGNOSTIC IMAGING	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
LAB TESTS	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
SURGERY	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
THERAPY	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
EQUIPMENT	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____
IN-HOME CARE	_____	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_____

PROJECTED HOURS: _____	EVERY	DD / WK / MO / YR	Total: $ _____

PROS

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CONS

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COMMENTS: _____
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