ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

DATE SUBMITTED: Month | Day | Year

TYPE OR PRINT LEGIBLY

CLAIM #:

PATIENT INFORMATION

1. PATIENT'S NAME — Last | First | Initial
2. PATIENT'S ADDRESS (No. Street)
3. CITY | 4. STATE
5. ZIP CODE | 6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE | 8. SEX ☐ M ☐ F
9. INSURANCE COMPANY
10. POLICY NUMBER
11. DATE OF ACCIDENT
12. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT? ☐ YES ☐ NO
B. AUTO ACCIDENT? ☐ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☐ NO
13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

14. POLICYHOLDER'S NAME — Last | First | Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY | 17. STATE
18. TELEPHONE # (Include Area Code) | 19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER — Last | First | Initial
22. TAX I.D. | 23. NPI | 24. SPECIALTY | 25. FACILITY OR OFFICE NAME
26. FACILITY /OFFICE ADDRESS (No. Street) | 27. CITY | 28. STATE | 29. ZIP CODE
30. TELEPHONE # (Include Area Code) | 31. EMAIL ADDRESS | 32.. FAX # (Include Area Code) | 33. INITIAL DATE OF TX | 34. DATE OF LAST VISIT

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD Ind. ☐ 9 ☐ 10

A. B. C. D.
E. F. G. H.
I. J. K. L.

37. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST — FROM (MM | DD | YY) → TO (MM | DD | YY)

PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT Purchase	EQUIPMENT Rental	SPINAL INJECTION Unilateral	SPINAL INJECTION Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

☐ **INCLUDE SUPPORTING DOCUMENTS**

FRAUD PREVENTION - NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

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SIGNATURE OF PROVIDER DATE