

## ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION       FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY			CLAIM #:	DATE SUBMITTED	Month	Day	Year
<b>PATIENT INFORMATION</b>				<b>POLICYHOLDER INFORMATION (if different)</b>			
1. PATIENT'S NAME Last      First      Initial			12. DATE OF ACCIDENT		15. POLICYHOLDER'S NAME Last      First      Initial		
2. PATIENT'S ADDRESS (No., Street)			13. IS PATIENT'S CONDITION RELATED TO:		16. POLICYHOLDER'S ADDRESS (No., Street)		
3. CITY		4. STATE	A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. CITY		18. STATE
5. ZIP CODE	6. TELEPHONE # (Include Area Code)		B. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. TELEPHONE # (Include Area Code)		20. ZIP CODE
7. PATIENT BIRTHDATE	8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. S.S. NUMBER	C. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. RELATIONSHIP TO PATIENT		
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES				
11. POLICY NUMBER							
<b>PROVIDER INFORMATION</b>							
22. NAME OF TREATING PROVIDER Last      First      Initial			23. TAX I.D. NUMBER		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)							
<input type="checkbox"/> ALL MEDICATION <input type="checkbox"/> MRI <input type="checkbox"/> SURGERY <input type="checkbox"/> XRAY <input type="checkbox"/> DIAGNOSTICS TESTING <input type="checkbox"/> OTHER							
36. PRIMARY DIAGNOSIS (ICD-9)		37. SECONDARY DIAGNOSIS (ICD-9)		38. ADDITIONAL DIAGNOSIS (ICD-9)		39. ADDITIONAL DIAGNOSIS (ICD-9)	
<b>PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA</b>							
40. DATE(S) OF TREATMENT REQUESTED FROM      TO			41. CHECK APPROPRIATE CARE PATH (If applicable)				
			<input type="checkbox"/> CP1 <input type="checkbox"/> CP2 <input type="checkbox"/> CP3 <input type="checkbox"/> CP4 <input type="checkbox"/> CP5 <input type="checkbox"/> CP6				
42. REQUEST FOR SERVICES : CPT / HCPS / NDC CODES							
(Use left box for single codes or left and right box for a range of codes)				FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (Number of weeks)	TOTAL UNITS
42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED <u>MUST</u> BE PROVIDED ON SEPARATE ATTACHMENT)							
<input type="checkbox"/> SOAP NOTES <input type="checkbox"/> PROGRESS NOTES <input type="checkbox"/> TEST RESULTS <input type="checkbox"/> MEDICAL HISTORY <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> OTHER							

### 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 REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43.

SIGNATURE OF PROVIDER

DATE