

## ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION       FOLLOW-UP SUBMISSION

<b>TYPE OR PRINT LEGIBLY</b>			<b>CLAIM #:</b>		<b>DATE SUBMITTED</b>		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"/> X-RAY	<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 / HCPCS / 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 <b>MUST</b> 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