ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION DATE SUBMITTED

TYPE OR PRINT LEGIBLY CLAIM #: Month Day Year

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 (38C) 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 → TO

MM	DD	YY	MM	DD	YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT New	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