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. RELATIONSHIPT 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. TELEPONE # (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 ☐ DIAGNOTIC TEST ☐ EXSISTING CONDISTIONS ☐ 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			PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)	EQUIPMENT		SPINAL INJECTION		DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS
MM	DD	YY	MM	DD	YY	CPT/HCPCS	New	Rental	Unilateral	Bilateral					

☐ **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