

ATTENDING PROVIDER TREATMENT PLAN

 INITIAL SUBMISSION

 FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY			CLAIM #:	DATE SUBMITTED	Month	Day	Year
PATIENT INFORMATION				POLICYHOLDER INFORMATION (if different)			
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)	
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		20. ZIP CODE
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES		21. RELATIONSHIP TO PATIENT		
11. POLICY NUMBER							
PROVIDER INFORMATION							
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)	
PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA							
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 MUST 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