ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY	CLAIM #:	DATE SUBMITTED	Month	Day	Year

PATIENT INFORMATION

1. PATIENT'S NAME Last	First	Initial	12. DATE OF ACCIDENT
2. PATIENT'S ADDRESS (No., Street)			13. IS PATIENT'S CONDITION RELATED TO:
3. CITY		4. STATE	A. EMPLOYMENT ☐ YES ☐ NO
5. ZIP CODE	6.TELEPHONE # (Include Area Code)		B. AUTO ACCIDENT? ☐ YES ☐ NO
7. PATIENT BIRTHDATE	8. SEX ☐ M ☐ F	9. S.S. NUMBER	C. OTHER ACCIDENT? ☐ YES ☐ NO
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK?
11. POLICY NUMBER			☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

15. POLICYHOLDER'S NAME Last	First	Initial
16. POLICYHOLDER'S ADDRESS (No.; Street)		
17. CITY		18. STATE
19. TELEPHONE # (Include Area Code)	20. ZIP CODE	
21. RELATIONSHIP TO PATIENT		

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)

☐ ALL MEDICATION ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTICS TESTING ☐ 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)
		☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ 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 **MUST** BE PROVIDED ON SEPARATE ATTACHMENT)

☐ SOAP NOTES ☐ PROGRESS NOTES ☐ TEST RESULTS ☐ MEDICAL HISTORY ☐ PRESCRIPTIONS ☐ 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