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
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. S.S. NUMBER
10. INSURANCE COMPANY
11. POLICY NUMBER
12. DATE OF ACCIDENT
13. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT ☐ YES ☐ NO
B. AUTO ACCIDENT? ☐ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☐ NO
14. IS PATIENT UNABLE TO WORK? ☐ 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