# 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 | 11. DATE OF ACCIDENT |
|---|---|---|---|
| | | | |

| 2. PATIENT'S ADDRESS (No. Street) | 12. 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 | C. OTHER ACCIDENT? ☐ YES ☐ NO |
|---|---|---|
| | | |

| 9. INSURANCE COMPANY | 13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES |
|---|---|
| | |

| 10. POLICY NUMBER |
|---|
| |

## 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 MM | DD | YY | TO 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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☐ **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.



SIGNATURE OF PROVIDER DATE