

# ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION       FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY      CLAIM #: 2005050100702      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)		20. ZIP CODE
7. PATIENT BIRTH DATE		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		21. RELATIONSHIP TO PATIENT
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				
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? CHECK MARK THOSE APPLICABLE (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)						BELOW.	
<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 FROM		REQUESTED 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 / 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. CHECK MARK 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