ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION

FOL	$I \cap V$	/-I IP	SHR	MSSION

										DATE SUBMITTED							
TYPE OR PRINT LEGIBLY							CLAIM #:					Month	Day	Year			
PATIENT INFORMATION												RINFORMAT	FORMATION (if different)				
	IENT'S I							11. DATE OF ACCIDENT				. POLICYHOLDEI			orr (ir airroront)		
Last					Fir	st	Initial			La			First		Initial		
2. PATIENT'S ADDRESS (No. Street)						12. IS PATIENT'S CONDITION RELATED TO:				15. POLICYHOLDER'S ADDRESS (No. Street)							
B. CITY 4. STATE							A. EMPLOYMENT? YES NO B. AUTO ACCIDENT? YES NO			16	16. CITY 17. STATE						
5. ZIP CODE 6. TELEPHONE # (Include Area Code)										18	18. TELEPHONE # (Include Area Code) 19. ZIP CODE						
7. PAT	IENT BI	RTHDA	TE			8. SEX	F	C. OTHER ACCIDENT?			20.	20. RELATIONSHIP TO PATIENT					
9. INSURANCE COMPANY										ABLE TO W	ORK?						
10. POLICY NUMBER							□ NO □ YES										
PRO	IDER	INFOR	MATI	DN													
				OVIDER				22. TAX I.D. 23. NPI				24. SPECIALT	Y	25. FACILITY OR OFFICE NAME			
Last						First	Initial										
26. FACILITY /OFFICE ADDRESS (No. Street)						27. CITY			28. STA		28. STATE	E 29. ZIP CODE					
30. TELEPHONE # (Include Area Code) 31. EMAIL ADDRESS							32 FAX # (Include Area Code) 33. INITIAL [33. INITIAL DA	ATE 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)																
		ATIONS		OF ILLN	**	SURGERY		AY D				EXISTING CO	NDITIONS ICD Ind.	COMORE		OTHER	
36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD I A. B. C. D.							ICD Ind.	□ a	10								
E.			F.				G.				н.						
l.	I. J.					К											
37. CH	ECK AF	PPROPE	RIATE C	ARE PA	TH (if app	licable)											
DROE			P1	TDE A	TMENT	CP2	CP3			CP4			CP5		CP6		
PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA 38. DATE(S) OF REQUEST PROCEDURES, SERVICES OR SUPI FROM TO (Explain Unusual Circumstances)																	
ММ	DD	YY	MM	DD	YY	CPT/HCPC	S	EQUIP Purchase		SPINAL IN Unilateral		POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS	

☐ 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.