523 Fellowship Rd, Suites 275/280
Mt. Laurel, NJ 08054
P. 856.596.5600 F.856.596.6300
www.prizmllc.com

«DateDocument»

«PersonName_To»
«CompnayName_To»
«Address_To»
«Fax_To»

RE: «PersonName_Claimant»
Claim #: «ClaimNumber»
DOL: «DateLoss»

«Dear»

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at http://www.nj.gov/dobi/filings.htm

Prizm, LLC has been selected by *AIG* as its PIP Vendor to implement their plan as required by the Automobile Cost Reduction Act. Prizm will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

If certain medically necessary services are performed without notifying *AIG* or Prizm a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification. Such treatment (within the first 10 days) shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

The Plan Administrator of this plan is:

Prizm, LLC
523 Fellowship Rd
Suites 275/280
Mt. Laurel, NJ 08054
Phone Number: 856-596-5600
Fax Number: 856-596-6300
Email Address Documents@Prizmllc.com

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

Please complete the attached "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to Prizm by fax (856-596-6300), or mail (523 Fellowship Rd, Suites 275/280, Mt. Laurel, NJ 08054) or email to TreatmentRequests@Prizmllc.com. This form can be accessed on Prizm's web site at www.Prizmllc.com. Any questions regarding your treatment request can be directed to Prizm at 856-596-5600 during regular business hours of Monday through Friday 8:00 AM to 5:00 PM, EST except for Federally and/or State Declared Holidays and/or New Jersey declared "State of Emergencies" related to inclement weather where travel is prohibited.

Decision Point Review

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Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as **Care Paths**, for soft tissue injuries, collectively referred to as **Identified Injuries**. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. *Decision Points* are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the eligible injured person or the health care provider must provide Prizm with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

Pursuant to N.J.A.C. 11:3-4.7, the New Jersey Department of Banking and Insurance, Prizm's Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, you as the treating provider are required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion Therapy
- Extended Care Rehabilitation Facilities
- All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Path's
- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation, including but not limited to re-evaluations except that provided for identified injuries in accordance with decision point review
- All Outpatient psychological/psychiatric treatment/testing and/or services
- All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
- Home Health Care

- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $100.00
- Non-Emergency medical transport with a round trip transportation in excess of $100
- Non-Emergency Dental Restorations
- Temporo-mandibular disorders; any oral facial syndrome
- Current Perception Testing
- Computerized Muscle Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Urine drug testing for prescription management or drug abuse identification
- Prescription Drugs costing more than $100.00
- Any all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPCS code

Decision Point Review/Pre-Certification Process

On behalf of *AIG*, Prizm will review all treatment plan requests and medical documentation submitted. A decision will be rendered three business days after the receipt of a completed Attending Provider treatment Plan form request with supporting medical documentation.

If additional information is requested, the decision will be rendered within three (3) days of our receipt of the additional information. In the event that *AIG* or Prizm does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If a decision is not rendered within three (3) business days of receipt of an "Attending Provider Treatment Plan " form, you, as the treating health care provider, may render medically necessary treatment until a decision is rendered.

All treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the NJDOBI web site www.nj.gov/dobi/aicrapg.htm or at Prizm's web site www.Prizmllc.com.

Failure to submit a completed Decision Point Review and Precertification treatment request, including but not limited to a completed "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified, within three (3) business days of the incomplete submission of what is needed to complete the precertification submission.

Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the injured person's condition, state the specific treatment and set treatment goals. AIG will not accept Decision Point Review/Precertification requests from the following providers;

- Hospitals
- Radiologic Facilities
- Durable Medical Equipment Companies
- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations
- Transportation Companies
- Suppliers of Prescription drugs/Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request Prizm will respond to them three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider. If another business or entity faxes an Attending Provider Treatment Plan form to Prizm, or requests notification of decision regarding requests for pre-certification, that business or entity will not receive same; Notifications will strictly be sent to the provider identified on the Attending Provider Treatment Plan who requested the specified treatment, testing, or Durable Medical Equipment.

As it relates to this Decision Point Review Plan, the follow applies when "Days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Response on Decision Point Review and Precertification Requests must be communicated to the treating provider no later than three business days after the submitted request. **Example:** A provider submits a proper request at Monday at 6:00 PM, which is 1 hour after the close of business hours at 5:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Decisions on pre-service appeals shall be communicated to the provider no later than fourteen (14) days from the date the insurer receives the appeal. **Example:** The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, January 8. Day one (1) of the fourteen (14) day period is Wednesday, January 9. The 14th day would be Tuesday, January 22, however there is a State of Emergency Declared in New Jersey on Tuesday January 22nd due to inclement weather. The insurer's decision is due no later than Wednesday, January 23, providing the State of Emergency has been lifted.

Decisions on post-service appeals shall be communicated to the provider no later than thirty (30) days from the date the insurer receives the appeal. **Example:** The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, June 28. Day one (1) of the thirty (30) day period is Wednesday, June 29. The 30th day would be Friday, July 29, as July 4 is a federally declared holiday.

Decisions that may be communicated to you:

Approved: A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.

Denied: A request for treatment/testing/Durable Medical Equipment is denied either by a Physician Advisor or an Independent Medical Examiner.

Modified: A request for treatment/testing/Durable Medical Equipment is modified either by a Physician Advisor or an Independent Medical Examiner.

Administrative Denial: Failure to submit "Attending Provider Treatment Plan" or an incomplete Decision Point Review and Precertification treatment request, including but not limited to an incomplete "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified, within three (3) business days of the incomplete submission of what is needed to complete the precertification submission. Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three (3) business days after the submission.

Retrospective DOS: If the request for treatment/testing/Durable Medical Equipment is for a Date of Service which has already occurred, a decision of Retrospective DOS will be rendered.

Pended to IME: If based on the Physician Advisor's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Restricted: Provider prohibited from submitting Decision Point Review/Precertification. Provider will be instructed that the submission must be made by the referring/treating provider.

Previously Requested: If the requested treatment/testing/Durable Medical Equipment has already been requested by the same provider (DOS and CPT codes) or an ancillary provider (related CPT codes to primary procedure i.e., anesthesia for surgery) a decision of previously requested will be entered and the decision of the previously requested service will be forwarded to the provider submitting the request.

Please note that the denial of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Pre-Certification

We encourage you, as the treating health care provider, to participate in a voluntary pre-certification process by submitting a comprehensive treatment plan to Prizm for all services provided. Prizm will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills you submit consistent with the agreed plan will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and Prizm to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

Independent Medical Examinations

Prizm or *AIG* may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline as the treating provider and the most appropriate specialty related to the treating diagnoses, as well as at a location reasonably convenient to the injured person Prizm will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless the insured/designee otherwise agrees to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. Upon completion of the Independent Medical Examination, you, as the treating provider, will be notified of the results by fax or mail within three business days after the examination. A copy of the examiner's report is available upon request. If AIG or Prizm fail to respond to the request within three business days of receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.

Prizm will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments.

The following will constitute an unexcused failure:

1. Failure of the Injured Party to attend a scheduled IME without proper notice to Prizm
2. Failure of the Injured party to notify Prizm at least two (2) days prior to the IME date
3. Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from [Insert Carrier name].
4. Failure to provide requested medical records, including radiology films, at the time of the IME
5. If the injured party, being examined does not speak English, failure to request or provide an English speaking Interpreter for the exam.

If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnoses) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and Cat Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by your treating provider). If you, the injured party utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, H-Reflex, NCV Studies, the 30% co-payment will not apply. In cases of prescriptions, the $10.00 co-pay of *AIG* will be waived if obtained from one of the pre-approved networks.

When one of the services listed below is authorized through AIG *Decision point review/Precertification* process, detailed information about voluntary network providers will be supplied to the claimant or requesting provider as noted below. Those individuals who choose not to utilize the networks will be assessed an additional co-payment not to exceed 30% of the eligible charge. That co-payment will be the responsibility of the claimant.

Once an MRI and/or Cat Scan Diagnostic test that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party, and schedule the test at a time and place convenient to them.

Durable Medical Equipment with a cost or monthly rental over $100.00 is subject to Decision Point Review/Pre-Certification process and once the *Durable Medical Equipment* is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. The equipment will be shipped to you; the injured party from the vendor, 24 hours after the request is received.

When you are in need of *Prescription* Drugs a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to you once the need for a prescription has been identified.

Once an Electro-diagnostic Test subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will then contact you, the injured party, and schedule the test at a time and place convenient to them. When Electrodiagnostic tests are performed

by your treating provider, in conjunction with a needle EMG H-Reflex, NCV Studies, the 30% co-payment will not apply.

Penalty Notification

Failure to submit requests for Decision Point Review or Pre-certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any co-payment stated in the insured's policy.

Assignment of Benefits

Health care providers that accept assignment for payment of benefits should be aware that they are required to hold harmless the injured person, insured or the insurance carrier for any reduction of benefits caused by the provider's failure to comply with the terms of the decision point/pre-certification plan. In addition, you must agree to submit disputes to our Internal Appeals Process prior to submitting any disputes through National Arbitration Forum as per N.J.A.C. 11:3-5. Failure to comply with the Decision Point Review /Pre-Certification Plan or the Requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy.

Please note that any provider that has accepted an assignment of benefits, must comply with and complete the Appeals Process as noted below prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

Internal Appeal Process

Pre-Service Appeals

You, as the treating provider, may request an internal pre-service appeal on any modified or denied services or other matters related to the treatment or care of the injured person. For appeals regarding a decision related to a treatment request, notification to Prizm must occur in writing within 30 days of the receipt of the decision in question. This appeal must be requested prior to the performance or issuance of the requested service. This appeal must contain a properly completed Pre-Service Appeal Form, the original Attending Provider Treatment Plan (APTP) being appeal, the APTP Decision/Response document being appealed, an appeal rationale narrative, the a provider's signature and the reason(s) for the appeal along with any supporting documentation. Prizm's response to the appeal will be communicated to the requesting provider in writing by fax within 14 days of receipt. The Pre-Service Appeals Form can be accessed on Prizm's web site at www.Prizmllc.com.

A properly completed Pre-Service Appeal Form must include:

- Date Appeal Submitted (box 1)
- Receipt Date of Adverse Decision (box 2)
- All Claim Information (boxes 3-5)
- All Patient Information (boxes 6-13)
- Provider/Facility Information (boxes 14-25)
- Required Documents attached
  - Original APTP Form
  - APTP Decision/Response document

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- Appeal rationale narrative
- Additional new supporting records

- Pre-service Appeal Issues (boxes 30-34 as appropriate)
  - Only one APTP should be submitted per Pre-Service Appeal Form. If multiple APTP's require a pre-service appeal, a separate Pre-Service Appeal Form should be submitted for each unique APTP.
- Signature of Provider (box 35)

The properly completed Pre-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 5480, Mt. Laurel, NJ 08054.

If the required information is not submitted at the time the pre-service appeal is received, the appeal will be denied administratively and will not be addressed. You will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

Please note that any provider that has accepted an assignment of benefits or any insured, must comply with the Appeals Process as noted below prior to initiating arbitration or litigations.

Post-Service Appeals

You, as the treating provider, may request an internal appeal for any and all issues, other than treatment denials or modifications done by a Physician Advisor Review or an IME subsequent to the performance or issuance of the services, a treating provider must request reconsideration through Prizm. These issues may include, but are not limited to, bill review or payment for services. This request must be made in writing within 90 days of receipt of the explanation of benefits and at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C 11:3-5. The request must include a properly completed Post-Service Appeal Form in accordance with NJAC 11:3-4.7(d) (as defined in section ii below), the original Bill (HCFA/UB), the Explanation of Benefit/Payment, the signature of the treating provider and reason(s) for reconsideration along with any additional supporting documentation.
A properly completed Post-Service Appeal Form must include:

- Date Appeal Submitted (box 1)
- Receipt Date of Adverse Decision (box 2)
- All Claim Information (boxes 3-5)
- All Patient Information (boxes 6-13)
- Provider/Facility Information (boxes 14-25)
- Required Documents attached
  - Original Bill (HCFA/UB)
  - Explanation of Benefit/Payment
  - Appeal rationale narrative
- Post-service Appeal Issues (boxes 30-38 as appropriate)
  - Only one EOB ID should be submitted per Post-Service Appeal Form. If multiple EOB's require a post-service appeal, a separate Post-Service Appeal Form should be submitted for each unique EOB ID.
- Signature of Provider (box 39)

The properly completed Post-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 5480, Mt. Laurel, NJ 08054.

Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within thirty (30) days after the receipt of the appeal form and any supporting documentation.

Please note that any provider that has accepted an assignment of benefits or any insured, must comply with the Appeals Process as noted above prior to initiating arbitration or litigations.

Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

One-Level Appeal Requirement

Each issue shall require one internal appeal submission prior to making a request for alternate dispute resolution. A request that has been denied administratively does not constitute an appeal. A pre-service appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than a post-service appeal of what the insurer should reimburse the provider for that same service. If a provider submits a pre-service appeal or the modification or denial of treatment by a Physician Advisor Review or an IME and subsequently performs the services and receives an EOB denial on the basis of the same PAR or IME, the one-level appeal requirement has been met and the provider is no longer able to appeal the same issue as a post-service appeal.

Payments/ Reimbursement

AIG will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees aren't noted in a fee schedule, AIG will use the most current version of FAIR Health Data Base, consistent with the date of service, 75th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee.

For Pharmacy bills which aren't noted in a fee schedule, AIG will use the most current version of RedBook with the geozip noted on the provider's address noted on this EOB.

If the provider participates in an applicable PPO network, services may be reimbursed in accordance with the amount permitted under the PPO agreement.

AIG has no obligation to reimburse for specific CPT/HCPC codes if they were approved (certified) in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of the AIG insurer's obligation to only reimburse for medically necessary treatment. To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/.

Dispute Resolution Process

If the treating provider is not satisfied with the results of Prizm's Internal Appeals Process, the treating provider may file with the Dispute Resolution governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, http://www.nj-no-fault.com. AIG retains the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits

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Mt. Laurel, NJ 08054
P. 856.596.5600 F.856.596.6300
www.prizmllc.com

The staff at Prizm remains available to you and your patient in order to assist with the Decision Point Review/Pre-Certification Process.

Sincerely,

Prizm, LLC

«Distribution»

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

DATE SUBMITTED: Month | Day | Year

TYPE OR PRINT LEGIBLY

CLAIM #:

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. INSURANCE COMPANY
10. POLICY NUMBER

11. DATE OF ACCIDENT

12. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT? ☐ YES ☐ NO
B. AUTO ACCIDENT? ☐ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☐ NO

13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

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)		EQUIPMENT		SPINAL INJECTION		DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS
CPT/HCPCS		New	Rental	Unilateral	Bilateral					

☐ 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.

39

SIGNATURE OF PROVIDER | DATE