ORDER NO.: A04-143

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE ESTABLISHMENT OF A UNIFORM ATTENDING PROVIDER TREATMENT PLAN FORM FOR DECISION POINT REVIEW AND PRECERTIFICATION IN PERSONAL INJURY PROTECTION	)))))	ORDER

This matter having been opened by the Commissioner of Banking and Insurance ("Commissioner") pursuant to the authority of N.J.S.A. 17:1-8.1, 17:1-15e, 39:6A-3.1 and 39:6A-4, N.J.A.C. 11:3-4.7(d) and all of the powers expressed and implied therein; and

IT APPEARING that pursuant to N.J.S.A. 39:6A-3.1, 39:6A-4 and N.J.A.C. 11:3-4, insurers must file Decision Point Review Plans with the Department that provide procedures for the prospective review by the insurer of requests for non-emergency treatment, testing or durable medical equipment made by the treating medical provider;

IT FURTHER APPEARING that insurers and providers have requested that the process of making such requests be made easier for insurers and providers to use; and

IT FURTHER APPEARING that a subcommittee of the Commissioner’s Personal Injury Protection Technical Advisory Committee (“PIPTAC”), composed of both insurer and provider representatives has developed a form for providers to use to submit treatment plans and requests for testing to insurers; and

IT FURTHER APPEARING that pursuant to N.J.A.C. 11:3-4.7(d), the Commissioner may, by Order, mandate the use of uniform forms by insurers and providers;

THEREFORE, IT IS on this 24th day of September, 2004:

ORDERED that:

1. Effective October 27, 2004, the Attending Provider Treatment Plan form, attached as Appendix A to this Order, shall be used by all providers to submit Decision Point Review and Precertification Requests. No other forms for this purpose are permitted. Insurers and vendors are encouraged to program the form on their websites, so that it can be downloaded, completed and printed by the provider.

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Holly C. Bakke
Commissioner

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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	12. DATE OF ACCIDENT
2. PATIENT'S ADDRESS (No., Street)	13. 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 / 9. S.S. NUMBER	C. OTHER ACCIDENT? ☐ YES ☐ NO
10. INSURANCE COMPANY	14. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES
11. POLICY NUMBER	

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		41. CHECK APPROPRIATE CARE PATH (If applicable)
FROM	TO	☐ 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