

CURE DECISION POINT REVIEW PLAN (DPRP) DISCLOSURE NOTICE

How To Comply with the DPRP Requirements Of Your CURE Policy

The '**Automobile Insurance Cost Reduction Act**' was signed into law on May 19, 1998, and it has led to changes in your no-fault (Personal Injury Protection or PIP) medical coverage. In enacting these reforms, the Legislature found that the substantial increase in the cost of medical expense benefits over the years had to be addressed by providing controls to eliminate medically unnecessary treatments, diagnostic testing and use of durable medical equipment.

As a result, in accordance with the provisions of your CURE auto policy including its **Decision Point Review Plan (DPRP)** requirements, you have certain obligations that you must satisfy so that we may provide coverage for medically necessary treatment, diagnostic testing and use of durable medical equipment arising from an automobile accident in which you are injured. **See EXHIBIT I** for a copy of the DPRP section of your PIP coverage provisions.

Failure to comply with the policy requirements as summarized below may affect the **reimbursement for medical treatment, diagnostic tests and durable medical equipment**. No decision point requirements shall apply within 10 days of the insured event or to treatment administered in emergency care.

YOUR OBLIGATIONS

1. **Treatment of "Identified Injuries"** Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, called **care paths**, for injuries of the neck and back, collectively referred to as the **identified injuries**. A more specific list of identified injuries is provided in **EXHIBIT II** attached.

The care paths provide that treatment of identified injuries must be evaluated at certain intervals called **decision points**. At **decision points**, you or your medical provider must provide **prior notice and supporting medical information** to CURE about further treatment and/or the use of durable medical equipment that is proposed.

If requests for decision point review are not submitted where required or clinically supported findings that support a request for treatment and/or durable medical equipment are not submitted, payment of your bills will be subject to a **penalty co-payment of 50%**, even if services are determined to be medically necessary.

The care paths and accompanying rules are available on the Internet at the website of the New Jersey Department of Banking and Insurance; <http://www.nj.gov/dobi/aicrapg.htm>.

2. **Diagnostic Tests** If your medical provider considers certain diagnostic tests to be medically necessary, this also requires decision point review as provided by N.J.A.C. 11:3-4, regardless of diagnosis, and you or your medical provider must notify us by providing written support and medical records required to establish the need for the test before we can consider it for coverage.

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EXHIBIT III attached provides a list of diagnostic tests requiring our **prior authorization**. **EXHIBIT IV** is a list of diagnostic tests that the law **prohibits** us from covering depending on circumstances. If requests for decision point review are not submitted where required or clinically supported findings that support requests for diagnostic tests are not submitted, payment of your bills will be subject to a **penalty co-payment of 50%**, even if the services are determined to be medically necessary.

3. **How To Notify CURE** See **EXHIBIT VI** attached for a copy of the **Attending Provider Treatment Plan form ("Treatment Plan")** your health care provider must complete when required to notify CURE of a proposed diagnostic test or treatment or use of durable medical equipment.

With the form, CURE's Decision Point Review Plan may require the submission of additional **clinical supporting** materials and medical records, including the supporting materials and medical records as specified below. The materials and records listed below fall under the heading "Other" as listed on the **Treatment Plan**, line 42.

SUPPORTING MATERIALS AND MEDICAL RECORDS

- | | |
|--------------------------------|---|
| 1. Initial Examination Report | 5. Attending Physician's Report (PIP-2) |
| 2. Patient Questionnaire | 6. Pertinent Medical Records and Medical Reports, Including |
| 3. Re-examination Reports | Reports of Referrals and Consultations, Obtained from Other |
| 4. Operative/Discharge Reports | Health Care Providers |

Please attach all other *supporting materials and medical records* pertinent to this injury.

You or your provider may call CURE at 1-800-535-2873, Extension 7596, for help and further information regarding these requirements and the use of the **Treatment Plan** form. The completed form can be mailed or faxed to CURE by your health care provider. **Our fax number is: 1-609-520-0097.**

CURE Response to Test or Treatment Notifications

Upon receipt of a completed Attending Provider Treatment Plan form as described in paragraph 3 above, we will (a) authorize the treatment, diagnostic test, or durable medical equipment; (b) deny the treatment, diagnostic test, or durable medical equipment; (c) request additional medical records and materials; or (d) advise that an independent medical examination ("*DPRP IME*") will be scheduled. Any decision we make to deny additional diagnostic tests, durable medical equipment or treatment will be based on the determination of a physician.

If we fail to do any of these four things within three business days after our receipt of the proper notice with all the required supporting materials and medical records as described in paragraph 3, then medically necessary treatment, use of durable medical equipment or diagnostic testing may continue without penalty until a final determination is communicated to you or your provider.

If requests for decision point review or clinically supported findings that support a request for treatment, diagnostic tests and/or durable medical equipment are not submitted where required, payment of your bills will be subject to a **penalty co-payment of 50% after application of the provisions of N.J.A.C. 11:3-29**, even if the services are determined to be medically necessary.

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Should a DPRP Independent Medical Examination be required, we will schedule the examination within 7 calendar days of our receipt of the notice from the treating provider, unless we have authorization from the injured person to extend this time period. The examination will be made with a provider in the same discipline as the treating provider and at a location reasonably convenient to the patient. The resulting decision will be communicated to the treating provider and the injured person within 3 business days after the examination. If the examining provider prepares a written report, a copy of the report shall be available upon request.

We may deny reimbursement of further treatment, request for the use of durable medical equipment and/or diagnostic testing for repeated unexcused failure of any "insured" to appear for a physical examination required by us. Repeated unexcused failure shall mean the failure to attend more than one scheduled appointment for a DPRP IME. If it is necessary for a patient to miss a scheduled IME, the patient must provide at least 72 hours notice by contacting CURE's IME Coordinator at (800) 535-2873, ext. 7596. Failure to attend the initial IME scheduled will be excused if timely notice is given to us.

Another examination will be scheduled for the patient to occur within the forty-five (45) calendar day period that will begin with our receipt of the patient's Decision Point Review Request. Failure to appear at any rescheduled appointment that is scheduled for a date within the initial forty-five (45) calendar day period will be excused if the patient provides at least 72 hours notice of unavailability.

Failure to attend an examination rescheduled to occur more than forty-five (45) calendar days from our receipt of the Decision Point Review Request will be considered unexcused.

The patient shall, if requested by us, provide medical records and other pertinent information to the health care provider conducting the physical examination. The requested records must be provided no later than the time of the examination. If the patient fails to supply the requested records at or before the scheduled examination, the examination may not take place and may be considered an unexcused failure to attend the examination.

After more than one unexcused failure to attend the scheduled IME, CURE will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. This denial will apply to treatment, diagnostic testing and durable medical equipment relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review request that necessitated the scheduling of the IME.

Written notification will be sent to the patient (or his/her designee) and all treating providers for the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form. This notification will advise that as of the notification date, no future treatment, diagnostic testing and/ or durable medical equipment associated with the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form will be eligible for payment.

Voluntary Network

In accordance with N.J.A.C. 11:3-4.8, the plan includes a voluntary network for certain tests and durable medical equipment specified in **EXHIBIT V**. When one of the specified tests or durable medical equipment is authorized through the decision point review process, information about our voluntary network will be supplied to the claimant and requesting provider. A list of network providers will be available by contacting the appropriate treatment plan reviewer by calling 1-800-535-2873. **Those individuals who choose not to utilize the network 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.

CURE DPRP Disclosure Notice: How To Comply with the DPRP Requirements of Your CURE Policy**Emergency Care**

Medically necessary treatment in the first ten days after the accident, and "emergency care" treatment or testing, do not require our prior authorization before coverage may be provided.

Reconsideration, Appeal and Dispute Resolution

If treatment, diagnostic testing or durable medical equipment is not authorized, you may request reconsideration through our internal Reconsideration and Appeals Process by submitting your request and supporting documentation in writing within 30 days of receipt of a written denial or modification. Submission of information identical to the original material submitted in support of the request shall not be accepted as a request for reconsideration. Provided that additional necessary medical information has been submitted, a response to the reconsideration request shall be made within 14 days. If it is determined that a peer review or an Independent Medical Examination is appropriate, this information will also be communicated within 14 days. Please note that any treating provider who has accepted an assignment of benefits must complete the Reconsideration and Appeals Process prior to initiating arbitration or litigation.

For disputes on issues other than requests for decision point review, any treating provider who has accepted an assignment of benefits must submit a written request for Reconsideration and Appeals specifying the issues in dispute accompanied by supporting documentation at least 21 days prior to initiating arbitration or litigation.

Any disputes not resolved in the Reconsideration and Appeals Process may be submitted through the Personal Injury Protection Dispute Resolution process which is 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 National Arbitration Forum (NAF) at 732-271-6100 or toll-free 1-888-881-6231. Information is also available on the NAF's Web site, <http://www.nj.adrforum.com/>. Unless emergent relief is sought, failure to utilize the Reconsideration and Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Assignment of Benefits

If you would like us to pay your treating medical provider directly, you must sign an Assignment of Benefits Agreement. As a condition of assignment, your provider must follow the requirements of this Decision Point Review Plan and shall hold you harmless for penalty co-payments imposed based on your provider's failure to follow the requirements of our Decision Point Review Plan. Failure to comply with (1) our Decision Point Review Plan Requirements or (2) the requirement to follow the Reconsideration and Appeals Process prior to initiating arbitration or litigation will render any prior assignment of benefits under the policy null and void.

Medical Necessity

This summary of CURE's Decision Point Review Plan requirements has been prepared for the convenience of our subscribers and their health care providers. However, please keep in mind that your policy contains additional provisions affecting whether there is coverage and how much you will be reimbursed.

All covered services and equipment, whenever provided and even if not subject to prior notification and review, must be medically necessary. For full details, please consult your policy and call us if you have questions. We are here to serve you.

Excerpted from:
 RS 05 77 09 09
 RB 05 76 09 09

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

1. Care Paths and Decision Points For "Identified Injuries" (Medical Protocols)

- a. The New Jersey Department of Banking and Insurance has established by regulation the standard courses of diagnosis and treatment for medical expenses resulting from "identified injuries". These courses of diagnosis and treatment are known as care paths. The care paths do not apply to treatment administered during "emergency care".
- b. Upon notification to us of a "bodily injury" covered under this policy, we will advise the "insured" of the care path requirements established by the New Jersey Department of Banking and Insurance.
- c. Where the care paths indicate a decision point, further treatment, the utilization of durable medical equipment or the administration of a "diagnostic test" is subject to our **Decision Point Review Plan**.

A decision point means the juncture in treatment where a determination must be made about the continuation or choice of further treatment of an "identified injury".

2. Coverage For "Diagnostic tests"

- a. In addition to the care path requirements for an "identified injury", the administration of any of the following "Diagnostic tests" is also subject to the requirements of our **Decision Point Review Plan**:
- (1) Brain audio evoked potential (BAEP);
 - (2) Brain evoked potential (BEP);
 - (3) Computer assisted tomographic studies (CT, CAT Scan);
 - (4) Dynatron/cyber station/cybex;
 - (5) H-reflex Study;
 - (6) Magnetic resonance imaging (MRI);

- (7) Nerve conduction velocity (NVC);
- (8) Somasensory evoked potential (SSEP);
- (9) Sonogram/ultrasound;
- (10) Visual evoked potential (VEP);
- (11) Any of the following "diagnostic tests" when not excluded under Exclusion C.
 - (a) Brain mapping;
 - (b) Doppler ultrasound;
 - (c) Electroencephalogram (EEG);
 - (d) Needle electromyography (Needle EMG);
 - (e) Sonography;
 - (f) Thermography/thermograms;
 - (g) Videofluoroscopy; or

(12) Any other "diagnostic test" that is subject to the requirements of our **Decision Point Review Plan** by New Jersey law or regulation.

- 1) The "diagnostic tests" listed under Paragraph 2.a. must be administered in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of "diagnostic tests" in evaluating injuries sustained in an auto accident. However, those requirements do not apply to "diagnostic tests" administered during "emergency care".
- 2) We will pay for other "diagnostic tests" which are:
 - (1) Not subject to our **Decision Point Review Plan**; and
 - (2) Not specifically excluded under Exclusion C.;

only if administered in accordance with the criteria for medical expenses as provided in this endorsement.

3. Decision Point Review Plan (Plan)

- a. Coverage for certain medical expenses under this endorsement is subject to this Decision Point Review Plan, which provides appropriate notice and procedural requirements

that must be adhered to in accordance with New Jersey law or regulation. We will provide a copy of this plan upon request, or in the event of any claim for medical expenses under this coverage.

b. Our Decision Point Review Plan includes the following minimum requirements as prescribed by New Jersey law or regulation:

(1) The requirements of the Decision Point Review Plan only apply after the tenth day following the accident and do not apply to **Emergency Care**.

(2) We must be provided prior notice, with appropriate "clinically supported" findings, that:

(a) Additional treatment for an "identified injury";

(b) The administration of a "diagnostic test" listed under Paragraph 2.a; or

(c) The use of durable medical equipment; is required.

The notice and "clinically supported" findings may include a comprehensive treatment plan for additional treatment.

c. Once we receive such notice with the appropriate "clinically supported" findings, we will, in accordance with our approved plan:

(1) Promptly review the notice and supporting materials; and

(2) If required as part of our review:

(a) Request any additional medical records; or

(b) Schedule a physical examination.

d. We will then determine, and notify the "insured", whether we will provide coverage for the additional treatment, use of durable medical equipment or "diagnostic test" within 3 business days of the receipt of the request or the receipt of additional medical records.

Any decision we make to deny authorization for additional treatment, use of durable medical equipment or diagnostic tests subject to our Decision Point Review Plan will be based on the determination of a physician.

e. Any physical examination of an "insured" scheduled as part of this plan, will be conducted as follows:

We will notify the "insured" that a physical examination is required as part of our review.

Should a DPRP Independent Medical Examination be required, we will schedule the examination within 7 calendar days of our receipt of the notice from the treating provider, unless we have authorization from the injured person to extend this time period. The examination will be made with a provider in the same discipline as the treating provider and at a location reasonably convenient to the patient. The resulting decision will be communicated to the treating provider and the injured person within 3 business days after the examination. If the examining provider prepares a written report, a copy of the report shall be available upon request.

We may deny reimbursement of further treatment, request for the use of durable medical equipment and/or diagnostic testing for repeated unexcused failure of any "insured" to appear for a physical examination required by us. Repeated unexcused failure shall mean the failure to attend more than one scheduled appointment for a DPRP IME. If it is necessary for a patient to miss a scheduled IME, the patient must provide at least 72 hours notice by contacting CURE's IME Coordinator at (800) 535-2873, ext. 7596. Failure to attend the initial IME scheduled will be excused if timely notice is given to us.

Another examination will be scheduled for the patient to occur within the forty-five (45) calendar day period that will begin with our receipt of the patient's Decision Point Review Request. Failure to appear at any rescheduled appointment that is scheduled for a date within the initial forty-five (45) calendar day period will be excused if the patient provides at least 72 hours notice of unavailability.

Failure to attend an examination rescheduled to occur more than forty-five (45) calendar days from our receipt of the Decision Point Review Request will be considered unexcused.

The patient shall, if requested by us, provide medical records and other pertinent information to the health care provider conducting the physical examination. The requested records must be provided no later than the time of the examination. If the patient fails to supply the requested records at or before the scheduled examination, the examination may not take place and may be considered an unexcused failure to attend the examination.

After more than one unexcused failure to attend the scheduled IME, CURE will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. This denial will apply to treatment, diagnostic testing and durable medical equipment relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review request that necessitated the scheduling of the IME.

Written notification will be sent to the patient (or his/her designee) and all treating providers for the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form. This notification will advise that as of the notification date, no future treatment, diagnostic testing and/or durable medical equipment associated with the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form will be eligible for payment.

f. Voluntary Network

Upon receiving notification of "bodily injury" covered under this policy, we may make available to the "named insured" and the treating "health care provider" information about our approved voluntary network providers for certain types of testing or durable medical equipment.

If an "insured" does not use a voluntary network provider, if requested by us, we may impose a co-payment not to exceed 30% of the eligible charges for "medically necessary" "diagnostic tests" or durable medical equipment.

This co-payment penalty will be in addition to any other applicable co-payment.

g. Penalty

A penalty will be imposed in accordance with our approved plan if:

- (1) We do not receive proper notice for treatment, "diagnostic tests" or the use of durable medical equipment in accordance with the requirements of our **Decision Point Review Plan**;
- (2) We are not provided with "clinically supported" findings; or

The co-payment penalty will be 50% of the lesser of:

- (1) The treating "health care provider's" usual, customary and reasonable charge; or
- (2) The upper limit of the medical fee schedule promulgated by the New Jersey Department of Banking and Insurance;

for any medical expenses incurred after notification to us is required but before authorization for continued treatment, the use of durable medical equipment or the administration of a "diagnostic test" is made by us.

The co-payment penalty will be in addition to any other applicable co-payment.

However, we will not impose a penalty when we received proper notice or are provided "clinically supported" findings and we failed to request further information, modify or deny reimbursement of further treatment, "diagnostic tests" or the use of durable medical equipment with respect to that notice or those findings in accordance with our plan.

A separate, additional co-payment of up to 30% of the eligible charges for "medically necessary" "diagnostic tests" or durable medical equipment may be imposed if an insured fails to use a network, if requested by us, in accordance with N.J.A.C. 11:3-4.8.

“IDENTIFIED INJURIES”

**“Identified Injuries”
Requiring Prior Notification and Review
at Decision Points**

- 1) Cervical Spine: Soft Tissue Injury;
- 2) Cervical Spine: Herniated Disc/Radiculopathy
- 3) Thoracic Spine: Soft Tissue Injury;
- 4) Thoracic Spine: Herniated Disc/Radiculopathy
- 5) Lumbar-Sacral Spine: Soft Tissue Injury;
- 6) Lumbar-Sacral Spine: Herniated Disc/Radiculopathy
- 7) Any other “bodily injury” for which the State of New Jersey Department of Banking and Insurance has established courses of diagnosis and treatment for medical expenses resulting from such injuries.

TESTS REQUIRING PRIOR NOTIFICATION AND REVIEW**Tests Requiring Prior Notification and Review
to Establish Medical Necessity**

1. Brain audio evoked potential (BAEP);
2. Brain evoked potential (BEP);
3. Computer assisted tomographic studies (CT, CAT Scan);
4. Dynatron/cyber station/cybex;
5. H-reflex Study;
6. Magnetic resonance imaging (MRI);
7. Nerve conduction velocity (NCV);
8. Somatosensory evoked potential (SSEP);
9. Sonogram/ultrasound;
10. Visual evoked potential (VEP);
11. Any of the following "diagnostic tests: when not excluded under Exclusion C.
 - a. Brain mapping;
 - b. Doppler ultrasound;
 - c. Electroencephalogram (EEG);
 - d. Needle electromyography (Needle EMG);
 - e. Sonography;
 - f. Thermography/thermograms; or
 - g. Videofluoroscopy;
12. Any other diagnostic test that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

PROHIBITED DIAGNOSTIC TESTS**Diagnostic Tests for Which the Law
Prohibits Coverage**

1. Brain mapping (when not done in conjunction with appropriate neurodiagnostic testing);
2. Iridology;
3. Mandibular tracking and stimulation;
4. Reflexology;
5. Spinal diagnostic ultrasound;
6. Surface electromyography (surface EMG);
7. Surrogate arm mentoring;
8. When used to treat temporomandibular joint disorder (TMJ/D):
 - a. Doppler ultrasound;
 - b. Electroencephalogram (EEG);
 - c. Needle electromyography (needle EMG);
 - d. Sonography;
 - e. Thermograms/thermographs;
 - f. Videoflourosopy; or
9. Any other diagnostic test that is determined to be ineligible for coverage under Personal Injury Protection Coverage by New Jersey law or regulation.

VOLUNTARY NETWORK SERVICES

**Services Subject to a 30% Co-Payment
If Not Provided by CURE's Voluntary Network**

1. Magnetic Resonance Imagery (MRIs);
2. Computer Assisted Tomography (CAT Scans);
3. Electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3, except when performed in conjunctions with a needle EMG by the treating physician; and
4. Durable medical equipment with a cost or monthly rental in excess of \$50.00.

ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY			CLAIM #:			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 BIRTHDATE		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"/> NO <input type="checkbox"/> YES									
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? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)												
<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 REQUESTED FROM 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. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED <u>MUST</u> 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