10 East Stow Road, Suite 100
Marlton, NJ 08053
P. 856.596.5600 F.856.596.6300
www.prizmllc.com

«DateDocument»

«PersonName_To»
«CompanyName_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 American Commerce Insurance Company 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 American Commerce Insurance Company 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
10 East Stow Road Suite 100
Marlton, NJ 08053
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 (10 East Stow Road Suite 100 Marlton, NJ 08053) 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.

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Decision Point Review

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. Videofluoroscopy
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 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

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- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $100.00
- 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
- Any all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPCS code

Decision Point Review/Pre-Certification Process

On behalf of American Commerce Insurance Company, 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 days of our receipt of the additional information. In the event that American Commerce Insurance Company 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 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.

In accordance with Order Number A04-143, 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 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. American Commerce Insurance Company 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.

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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 treatment appeals shall be communicated to the provider no later than 10 business 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 of the 10- business day period is Wednesday, January 9. The 10th business 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 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 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 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. An additional copayment penalty 50% may be imposed on any such treatment/testing/DME determined to be clinically supported and medically necessary.

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.

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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 American Commerce Insurance Company 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 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 American Commerce Insurance Company 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 flowing 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 American Commerce Insurance Company.
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 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

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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). The failure to use one of our pre-approved networks vendors will result in the imposition of an additional 30% (thirty) co-payment for any services deemed to be medically necessary. 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 American Commerce Insurance Company will be waived if obtained from one of the pre-approved networks.

When one of the services listed below is authorized through American Commerce Insurance Company's *Decision point review/Precertification* process, detailed information about voluntary network providers will be available 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 a diagnostic 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 request decision point review or pre-certification where required or failure to provide clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested shall result in an additional copayment of 50% of the eligible charge for such. The co-payment shall apply to the treatment, diagnostic test or durable medical equipment that was rendered between the time of required notification to Prizm and the time Prizm communicated the decision 3 business days after the receipt of the request. Such treatment, diagnostic testing or durable medical equipment 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.

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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 or any insured, must comply with the Appeals Process as noted below prior to initiating arbitration or litigations.

Internal Appeal Process

Appeals Regarding a Decision related to a Treatment Request

You, as the treating provider, may request an internal 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 within 10 business days of the receipt of the decision in question. This appeal must be made in writing by fax, mail or by accessing the Internal Appeals Form on the web site at which point further documentation can be discussed with a physician advisor. This appeal must contain the treating provider's signature and the reason for the appeal. Prizm's response to the appeal will be communicated to the requesting provider in writing by fax within ten business days of the receipt. An Internal Appeals Form can be accessed on Prizm's web site at www.Prizmllc.com.

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.

Appeals Regarding any Issue other than a Decision Related to a Treatment Request

You, as the treating provider, may request an internal appeal for any and all issues. These issues may include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing stating the issue being disputed along with supporting documentation within 30 (thirty) days of the issuance of the decision that is the subject of the appeal. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within 10 business days of the receipt of the request. If you, as the treating provider, have a valid assignment of benefits, this appeal must be submitted to Prizm no later than 21 days prior to the initiation of any arbitration or litigation.

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.

Payments/ Reimbursement

American Commerce Insurance Company 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, American Commerce Insurance Company will use the most current version of FAIR Health Data Base, consistent with the date of service, 80th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee.

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

American Commerce Insurance Company has no obligation to reimburse for specific CPT/HCPCS 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 American Commerce Insurance Company'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. American Commerce Insurance Company 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

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»

«RequestID»

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