



TBI Medical Document Form

The following guide only explains how to fill out the TBI Medical Documentation Form by the healthcare provider. The healthcare provider receives an email with a direct link to the form after a patient/requester provides the Healthcare Provider's credentials.

1. Navigate to your email.
2. Select **Review Online**.



Traumatic Brain Injury Fund Application



A New Application Received - Required Health Care Provider Review

Dear John Smith,

We received an application to the NJ Traumatic Brain Injury (TBI) Fund from one of your patients. To determine eligibility, medical documentation of the TBI is required from their medical doctor or neuropsychologist.

Please find Patient's Basic Information as below:

First Name: Jane
Last Name: Doe

Address : Trenton, New Jersey, Mercer County
Apt/Unit/Suite/P.O.Box Number: 343
Phone: (123) 456-7879

ACTION REQUIRED: [Review online](#) to fill in the medical information.

**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
PURSUANT TO 45 CFR 164.508 "**


: I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and that medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA).


Name: Jane Doe **Last Name:** Doe
Date: 07/24/2024
Signature: Signed By: Jane Doe - roni.cohen@dhs.nj.gov
Date Signed: 07/26/2024 7:34:46 PM +00:00 GMT
IP Address: 75.197.53.119,170.85.70.102

If you have any questions, please reach out to the NJ TBI Fund at Dhsco.DDS-TBIFund@dhs.nj.gov or 1-888-285-3036

*Please do not respond directly to this e-mail. The originating e-mail account is not monitored.
Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, destroy all copies of the original message.*

The following form is displayed:



TRAUMATIC BRAIN INJURY FUND MEDICAL DOCUMENTATION FORM


This form must be completed and signed by a licensed medical doctor or neuropsychologist.

N.J.A.C. 17:27, the statute that regulates the Traumatic Brain Injury Fund, utilizes the following definition of brain injury:

"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury resulting in disruption of the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances.


HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and that medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, I certify that the information provided is true, correct and complete to the best of my knowledge. I also certify that I have read and understand my responsibilities under this Fund.

Name
 glg

Date
 08/13/2024

Signature


Your Physician Name
 glg

To be filled out by the medical provider. Items in * are required fields.

Provider Name *

Provider license Number *

Type of Provider *

Address *

Ap/Linc/State/POBox Number

Phone *

Email *

Website

Does the patient meet the TBI definition?

"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury resulting in disruption of the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances. *

☐ Yes
☐ No

Name *


Date *

☐ I certify that my patient, named above, has been diagnosed with a Traumatic Brain Injury as described above and that the ICD-10 code data specified for this patient represents a true and accurate diagnosis. *


Signature *

Signer's Name **Type** **Draw** **Upload** **Clear**

3. Review information provided.



TRAUMATIC BRAIN INJURY FUND MEDICAL DOCUMENTATION FORM



This form must be completed and signed by a licensed medical doctor or neuropsychologist.

N.J.A.C. 10:141, the statute that regulates the Traumatic Brain Injury Fund, utilizes the following definition of brain injury:

"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances.

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and that medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, I certify that the information provided is true, correct and complete to the best of my knowledge. I also certify that I have read and understand my responsibilities under this Fund.

Name	Date
Jane Doe	07/24/2024
Signature	
<i>Jane Doe</i>	
Your Physician Name	
John Smith	

4. Enter the required information.

To be filled out by the medical provider. Items in * are required fields.

Provider Name * <input type="text"/>	Provider license Number * <input type="text"/>
--	--

5. Select an option from the drop-down menu.

Type of Provider *

-- Select one --

-- Select one --
Medical Doctor
Neuropsychologist

6. Enter the required information.

Address *	
<input type="text"/>	
Apt./Unit/Suite/POBox Number	Phone *
<input type="text" value="e.g Apt/unit/suite"/>	<input type="text"/>
Email *	Website
<input type="text"/>	<input type="text"/>

7. Select **Yes**, or **No**.

Does the patient meet the TBI definition?

"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances. *

☐ Yes
☐ No

Note: If you selected Yes, please complete [Section 7a](#) before question 8. If you selected No, please continue to question 8.

Section 7a

7a. Enter the required and relevant information.

Does the patient meet the TBI definition?

"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances. *

☒ Yes
☐ No

How long have you been treating them as a patient?

Please attach at least one of the following documents to support the TBI diagnosis

ICD-10 *	ICD-10	ICD-10
<div></div>	<div></div>	<div></div>
ICD-10	ICD-10	ICD-10
<div></div>	<div></div>	<div></div>

7b. Select the type of supporting document(s).

7c. Attach supporting files by selecting, **Select files...**

Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files... A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.

Please attach at least one of the following documentations to support the TBI Diagnosis *

☐ Records (ICD-10 Code) verifying TBI
☐ Supporting report
☐ Other diagnosis; and/or Neuropsychological evaluation(s)

Attach one or more document(s) here *

Select files...

7d. Select the **Year TBI occurred (yyyy)**.

Year most recent TBI occurred (yyyy) *

-- Select one --

2024

2023

2022

2021

2020

2019

2018

7e. Enter or select a **Date TBI occurred (mm/dd)**.

7f. Enter the **Cause of TBI**.

Date TBI occurred (mm/dd)

MM/dd

← July 2024 →

Su	Mo	Tu	We	Th	Fr	Sa
30	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

Today

Cause of TBI *

7g. Enter the required and relevant information.

Are there other medical conditions that have arisen as a direct result of the TBI? *

Treatments received for TBI *

7h. Select **Yes**, or **No**.

Will this condition require ongoing treatment and support? *

☐ Yes

☐ No

7i. Select the relevant information.

Treatment(s) Recommended (check all that apply)

<input type="checkbox"/> Acupuncture/Acupressure	<input type="checkbox"/> Financial Management	<input type="checkbox"/> Structured Day Program
<input type="checkbox"/> Aqua Therapy	<input type="checkbox"/> Hippotherapy	<input type="checkbox"/> Substance Abuse Evaluation/Treatment
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Household Management	<input type="checkbox"/> Medical Transportation
<input type="checkbox"/> Behavior Management	<input type="checkbox"/> Life Skills Training	<input type="checkbox"/> Vehicle Modification
<input type="checkbox"/> Biofeedback/Neurofeedback	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Vision Care
<input type="checkbox"/> Chiropractic Therapy	<input type="checkbox"/> Neuropsychiatric/Neuropsychological	<input type="checkbox"/> Case Management
<input type="checkbox"/> Cognitive Rehabilitation Therapy	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Tutoring
<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Dental Care	<input type="checkbox"/> Personal Care	<input type="checkbox"/> Protective Legal Services
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Educational Service	<input type="checkbox"/> Service Coordination	<input type="checkbox"/> Environmental/Home Modifications
<input type="checkbox"/> Speech-Language Therapy		

8. Enter your **Name** and **Date**.
9. Read the statement and select the box if you certify.
10. **Type, Draw, or Upload** your **Signature**.
11. Select **Save** if you would like to come back to the form at a later time.
Select **Submit** once you are ready to complete the form.

Name *

Date *

08/14/2024

☐ I certify that my patient, named above, has been diagnosed with a Traumatic Brain Injury as described above and that the ICD-10 code data specified for this patient represents a true and accurate diagnosis. *

Signature *

×

Signer's Name

Type Draw Upload Clear

Note: All attachments combined size should be less than 30MB.
If you are facing any issues submitting this application online, please contact the NJ TBI Fund at DHSCO.DDS-TBIFund@dhs.nj.gov or call 1-888-285-3036.

Save

Submit

The following message is displayed once you have submitted the form.





Traumatic Brain Injury Fund Application

Thank you for contacting the NJ Department of Human Services.
Your submission (TRAUMATIC BRAIN INJURY FUND: MEDICAL DOCUMENTATION FORM) has been received and will be reviewed by the appropriate staff.