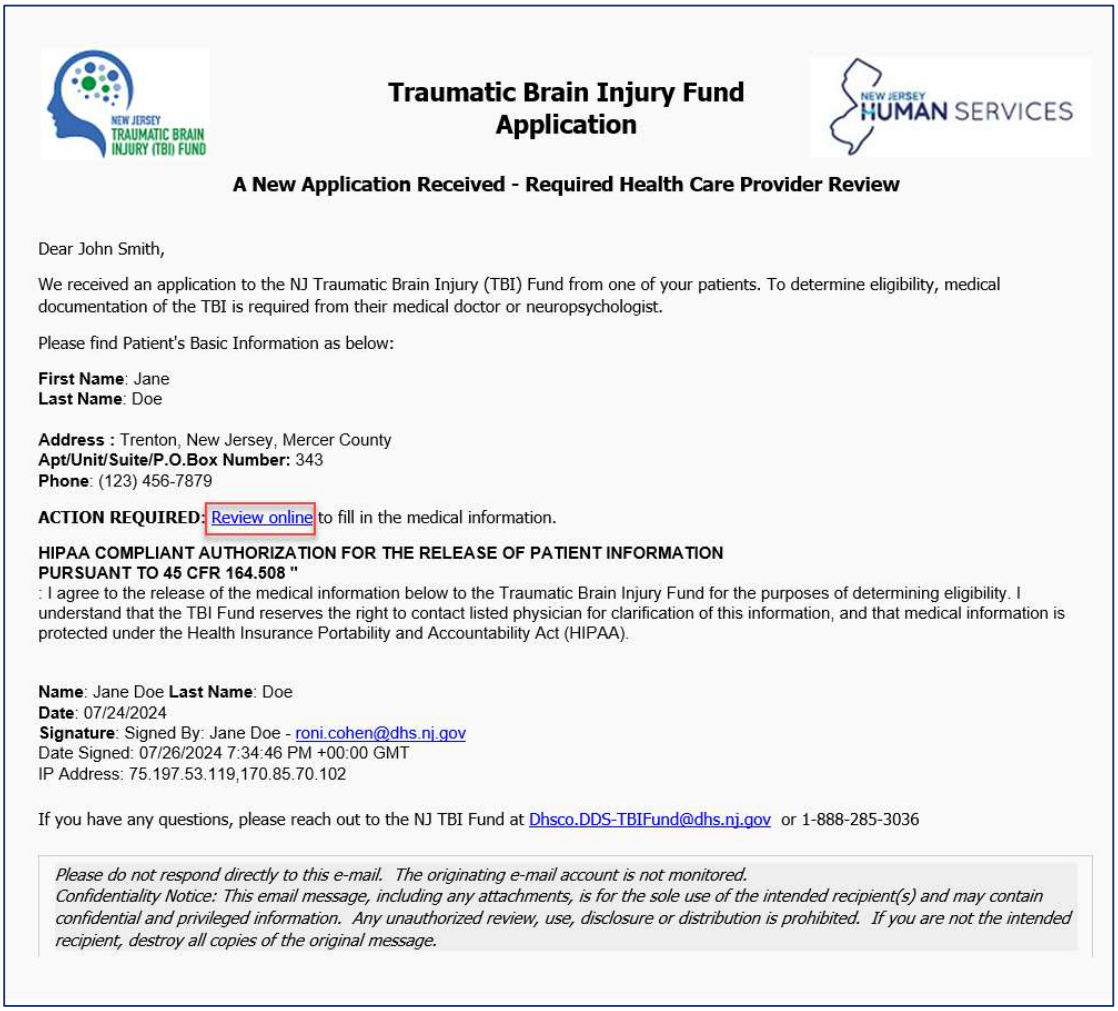
TBI Medical Document Form

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.

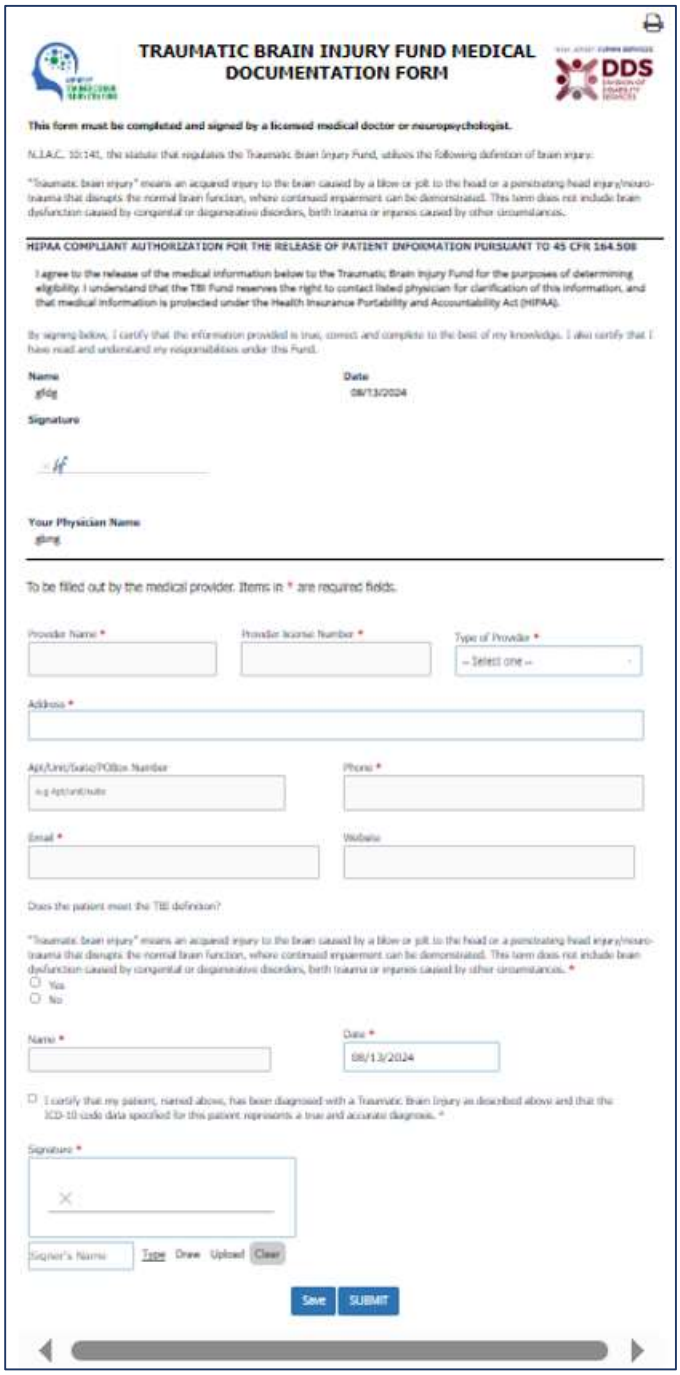
HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508 "
: I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed 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. 10:148, 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 contrived 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
gfdg

Date
08/13/2024

Signature

Your Physician Name
gfdg

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

Provider Name *

Provider license Number *

Type of Provider *
-- Select one --

Address *

Apt/Unit/Suite/POBox Number
e.g. Apt/Unit/Suite

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/neuro-trauma that disrupts the normal brain function, where contrived 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 *
08/13/2024

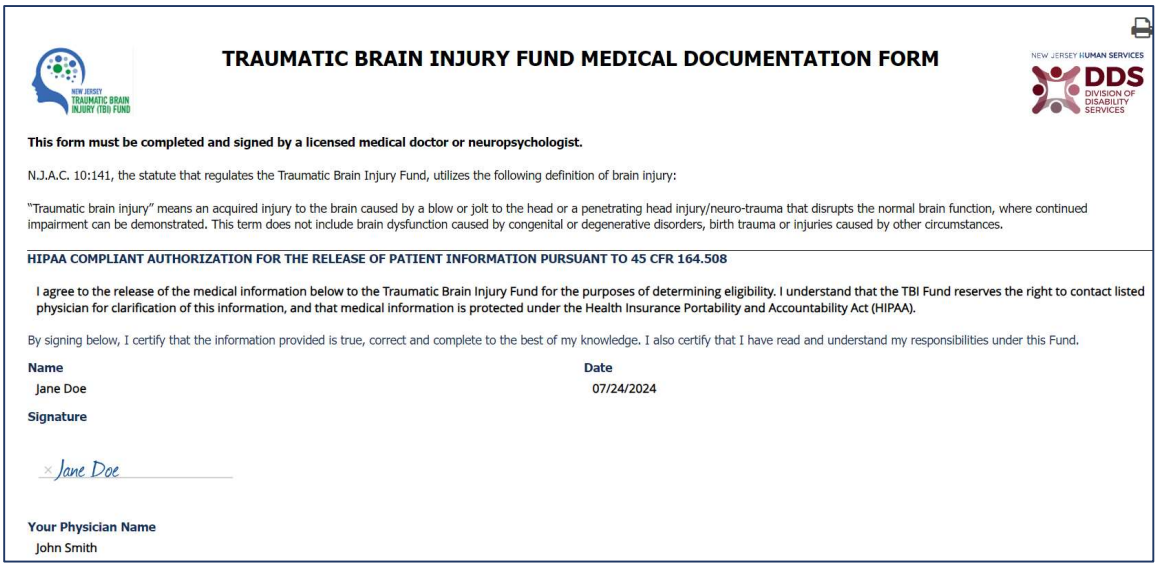
I certify that my patient, named above, has been diagnosed with a Traumatic Brain Injury as described above and that the ICD-10 code data specified for this patient represents a true and accurate diagnosis. *

Signature *

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

Save | SUBMIT

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 Jane Doe

Date 07/24/2024

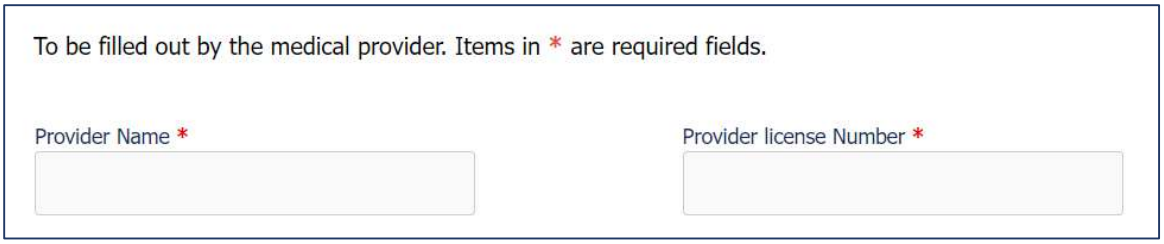
Signature

Jane Doe

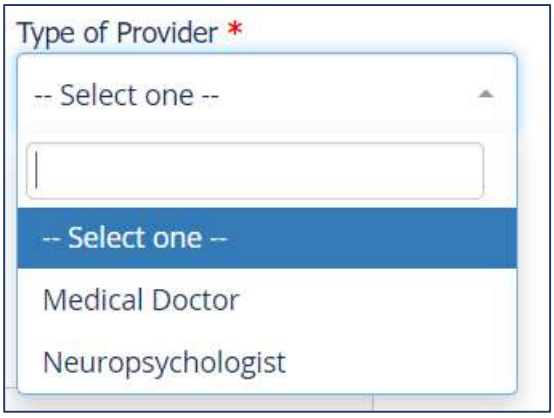
Your Physician Name

John Smith

4. Enter the required information.

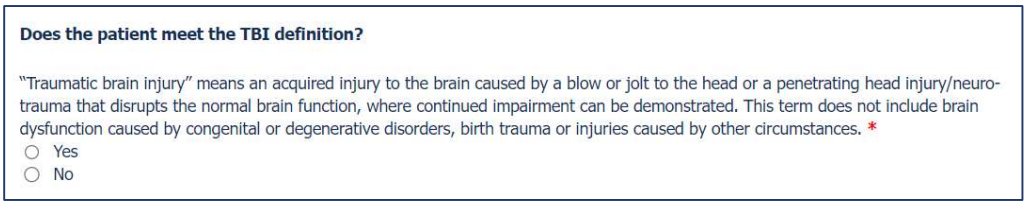


5. Select an option from the drop-down menu.



6. Enter the required information.

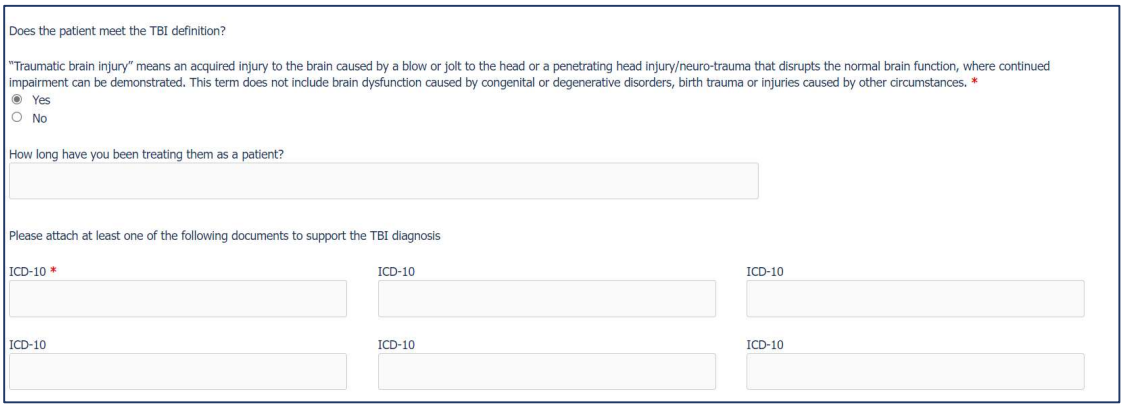
7. Select **Yes,** or **No**.



Note: If you selected Yes, please complete Section 7a before question 8. If you selected No, please continue to question 8.

Section 7a

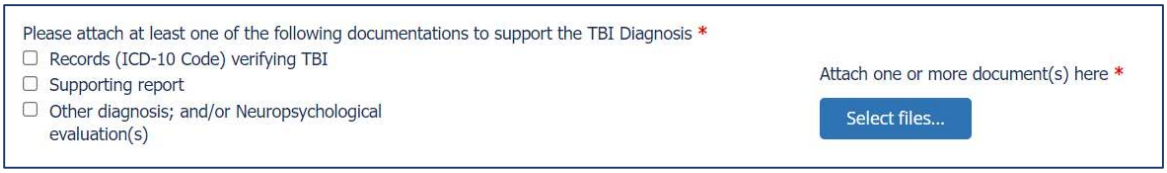
7a. Enter the required and relevant information.



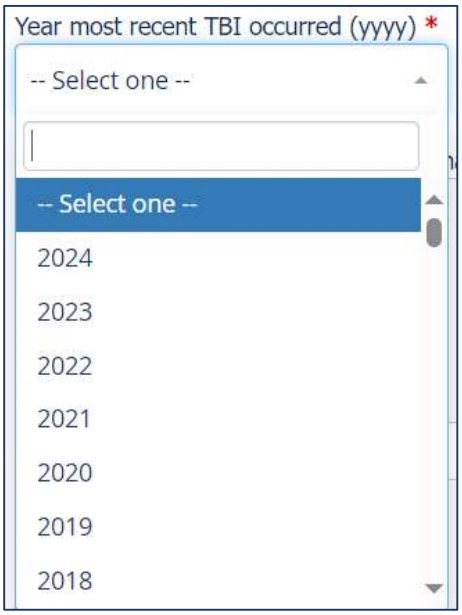
7b. Select the type of supporting document(s).

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.

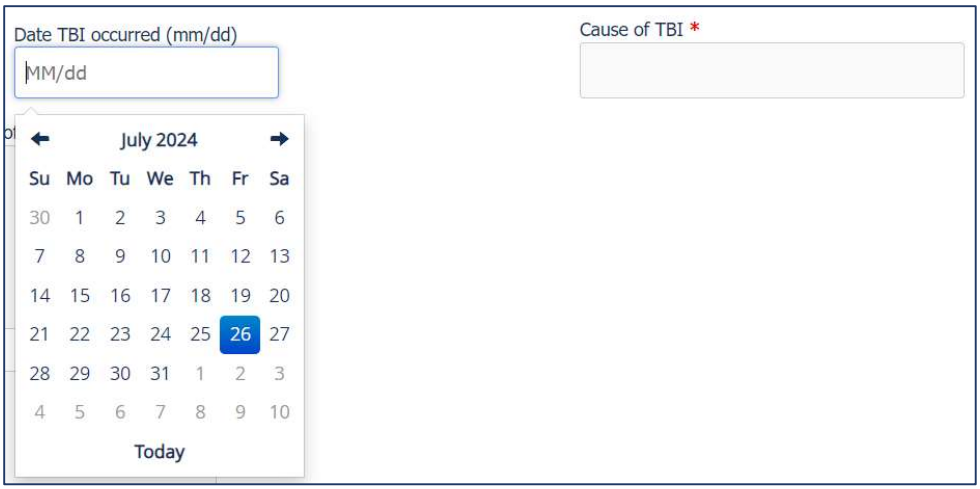


7d. Select the **Year TBI occurred (yyyy).**

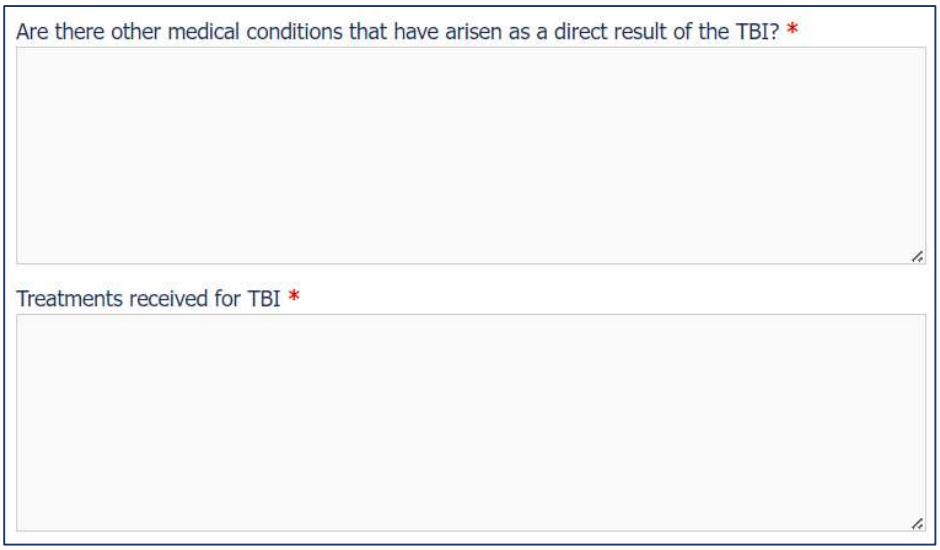


7e. Enter or select a **Date TBI occurred (mm/dd).**

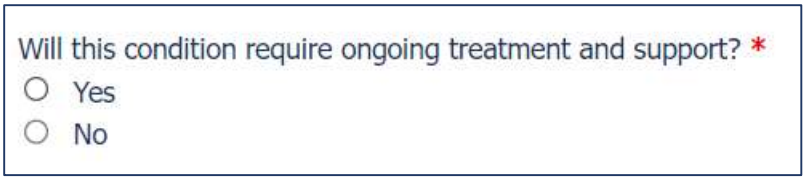
7f. Enter the **Cause of TBI**.



7g. Enter the required and relevant information.

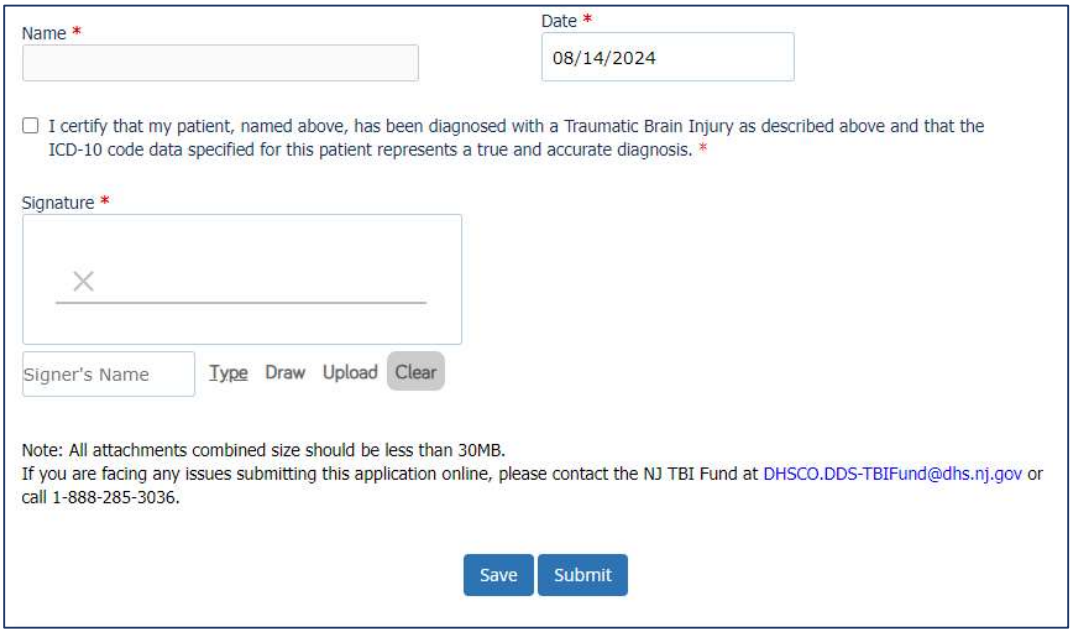


7h. Select **Yes**, or **No**.



7i. Select the relevant information.

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 like to come back to the form at a later time.
    Select **Submit** once you are ready to complete the form.



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