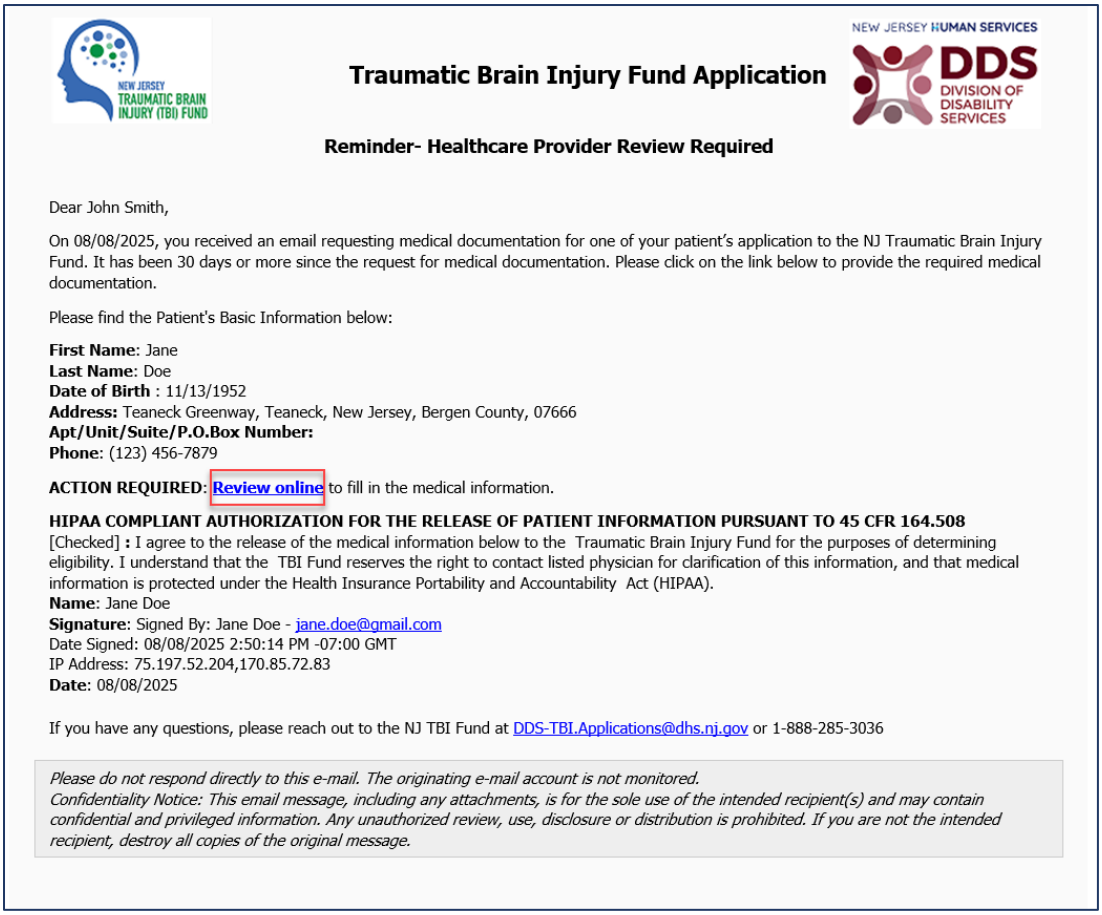
TBI Medical Document Form

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

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



Traumatic Brain Injury Fund Application

Reminder- Healthcare Provider Review Required

Dear John Smith,

On 08/08/2025, you received an email requesting medical documentation for one of your patient's application to the NJ Traumatic Brain Injury Fund. It has been 30 days or more since the request for medical documentation. Please click on the link below to provide the required medical documentation.

Please find the Patient's Basic Information below:

First Name: Jane
Last Name: Doe
Date of Birth : 11/13/1952
Address: Teaneck Greenway, Teaneck, New Jersey, Bergen County, 07666
Apt/Unit/Suite/P.O.Box Number:
Phone: (123) 456-7879

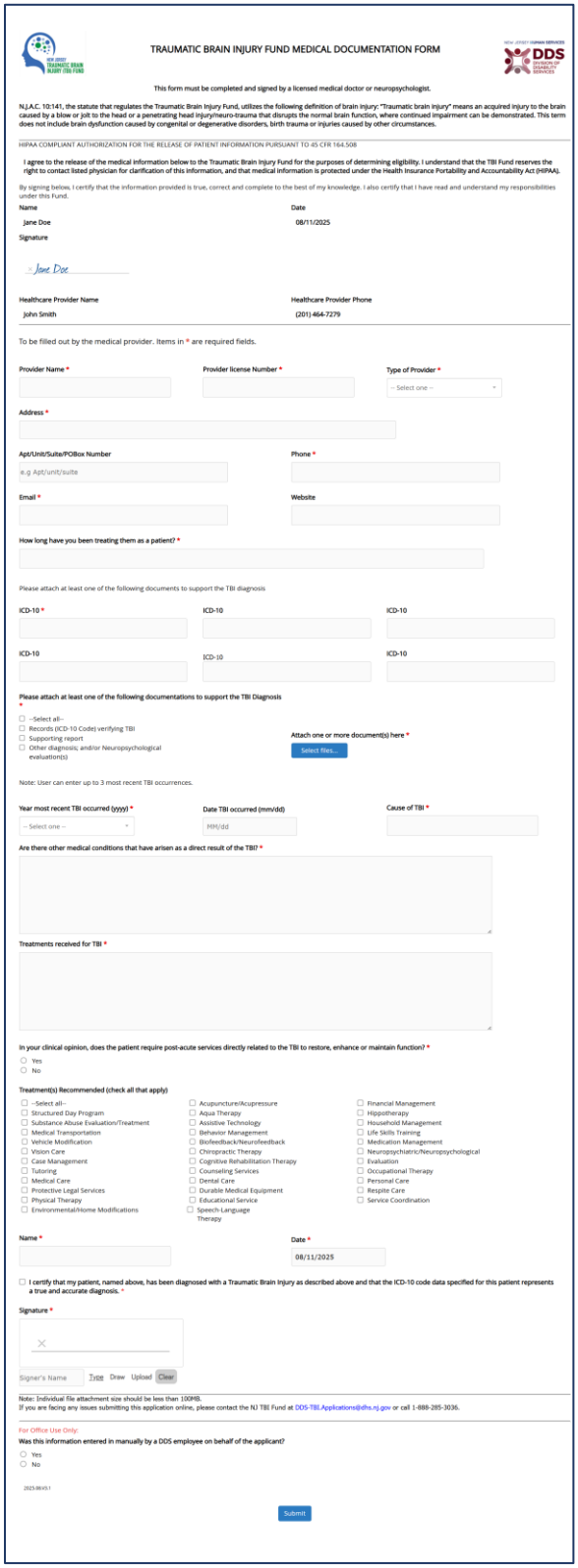
ACTION REQUIRED: **Review online** to fill in the medical information.

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508
[Checked] **:** 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
Signature: Signed By: Jane Doe - jane.doe@gmail.com
Date Signed: 08/08/2025 2:50:14 PM -07:00 GMT
IP Address: 75.197.52.204,170.85.72.83
Date: 08/08/2025

If you have any questions, please reach out to the NJ TBI Fund at DDS-TBI.Applications@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. 10:141, 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: 08/11/2025
Signature: Jane Doe
Healthcare Provider Name: John Smith
Healthcare Provider Phone: (201) 464-7279

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
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
ICD-10 | ICD-10 | ICD-10

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

- [ ] --Select all--
- [ ] Records (ICD-10 Code) verifying TBI
- [ ] Supporting report
- [ ] Other diagnostic and/or Neuropsychological evaluation(s)

Attach one or more document(s) here * Select files...

Note: User can enter up to 3 most recent TBI occurrences.

Year most recent TBI occurred (yyyy) * -- Select one --
Date TBI occurred (mm/dd) MM/dd
Cause of TBI *

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

Treatments received for TBI *

In your clinical opinion, does the patient require post-acute services directly related to the TBI to restore, enhance or maintain function? *

- ○ Yes
- ○ No

Treatment(s) Recommended (check all that apply)

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

Name *
Date * 08/11/2025

- [ ] 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: Individual file attachment size should be less than 100MB.
If you are facing any issues submitting this application online, please contact the NJ TBI Fund at DDS-TBI.Applications@dhs.nj.gov or call 1-888-285-3036.

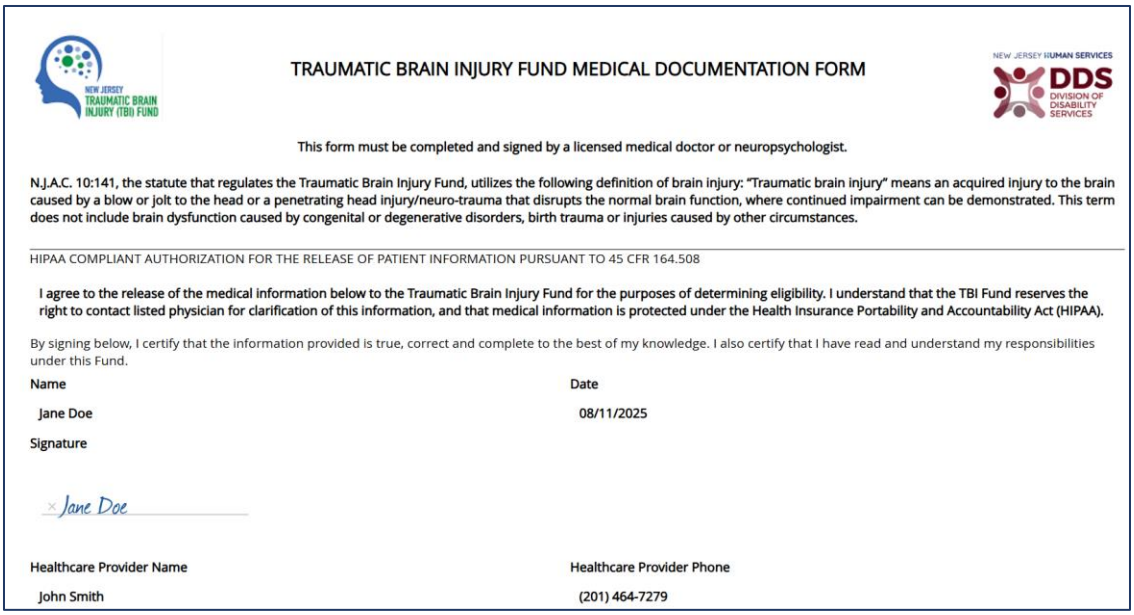
For Office Use Only:
Was this information entered in manually by a DDS employee on behalf of the applicant?

- ○ Yes
- ○ No

2025.09.V.1

Submit

3. Review information provided.



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Name: Jane Doe

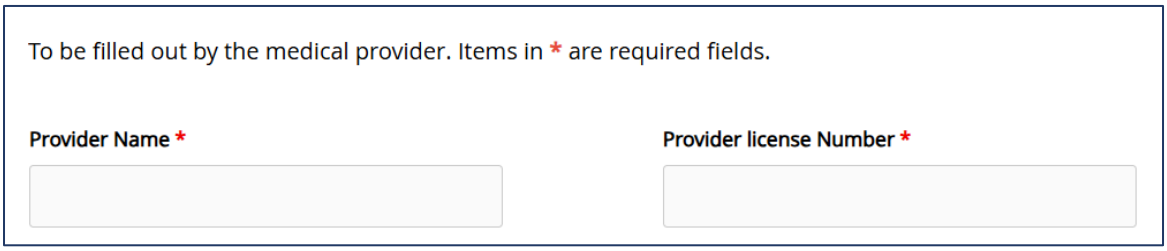
Date: 08/11/2025

Signature: Jane Doe

Healthcare Provider Name: John Smith

Healthcare Provider Phone: (201) 464-7279

4. Enter the required information.

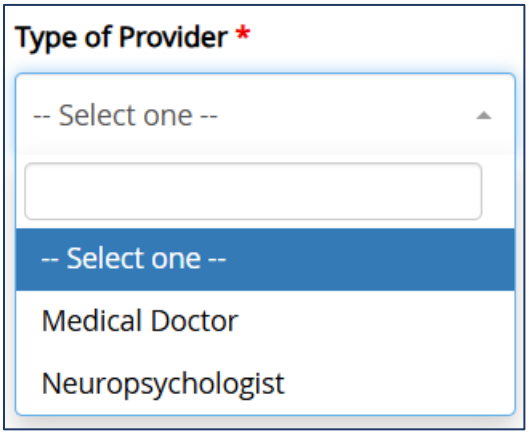


To be filled out by the medical provider. Items in * are required fields.

Provider Name *

Provider license Number *

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



Type of Provider *

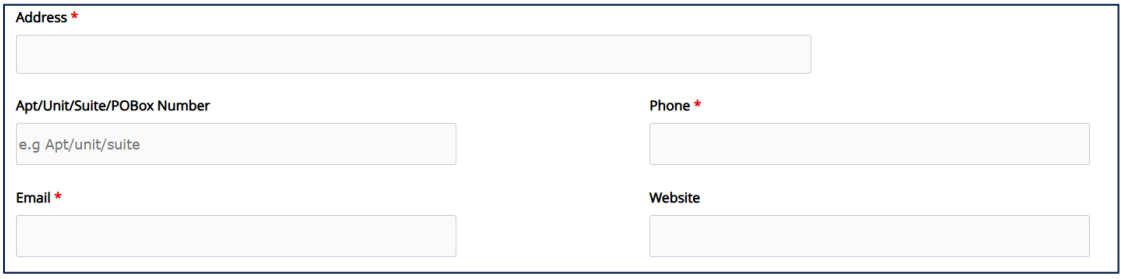
-- Select one --

-- Select one --

Medical Doctor

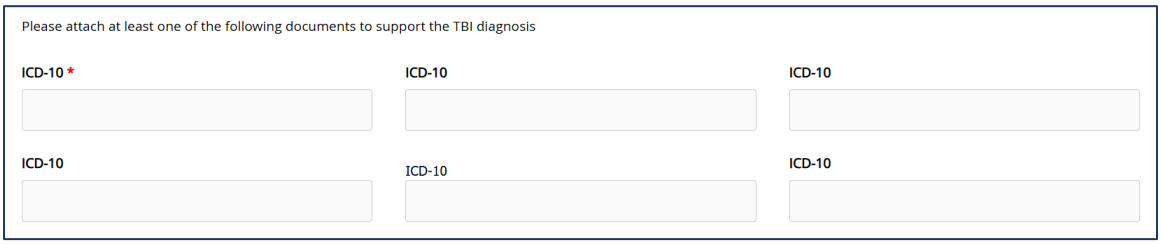
Neuropsychologist

6. Enter the required information.



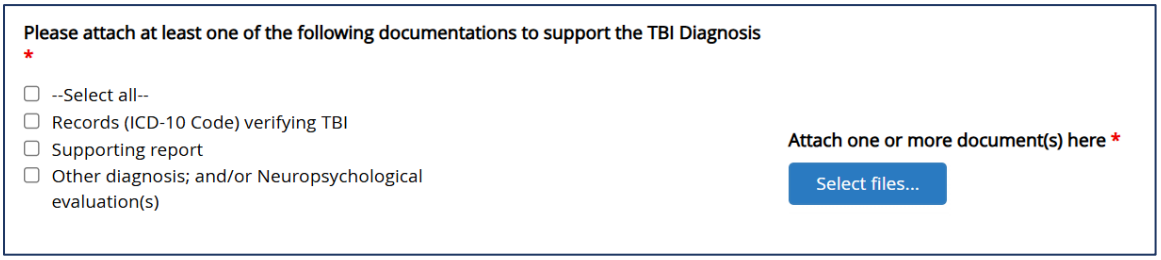
7. Enter the required information.

8. Enter the required and relevant information.

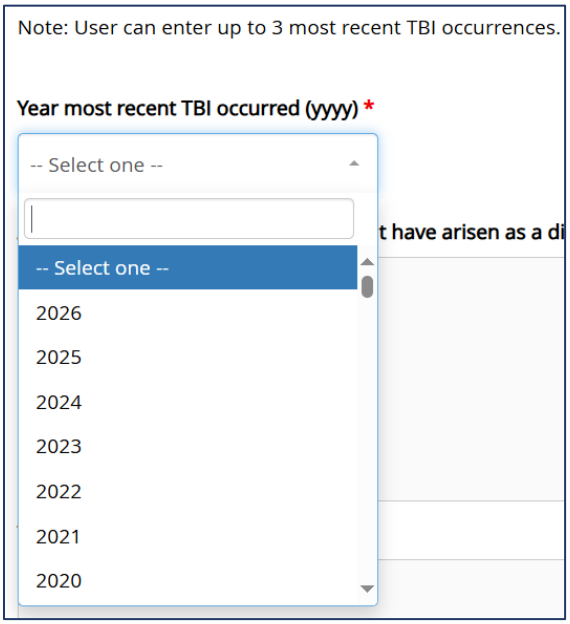


9. Select the type of supporting document(s).
10. Attach supporting files by selecting, **Select files…**

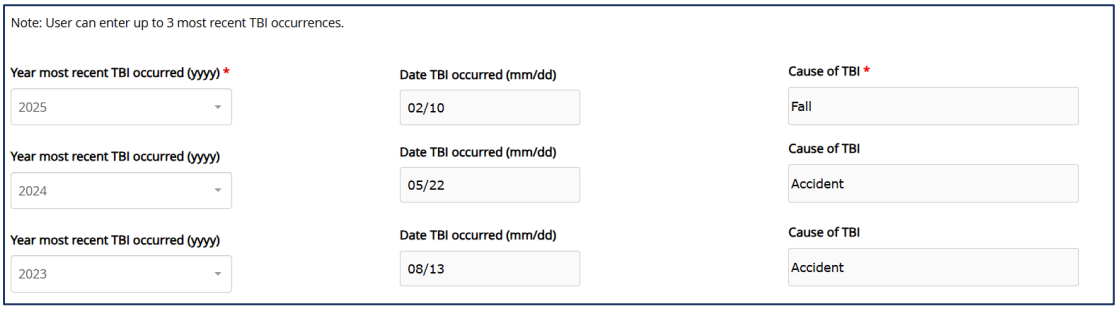
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document,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



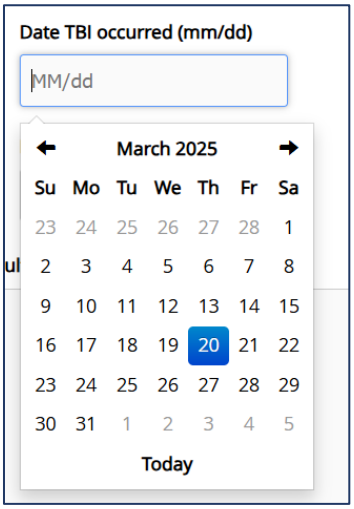
11. Select the **Year most recent TBI occurred (yyyy).**



Note: An extra row of the same fields appears when you select a year from the "Year most recent TBI occurred (yyyy)" drop-down menu. In total, the identical fields can appear up to three times for three different most recent of TBI occurrences.

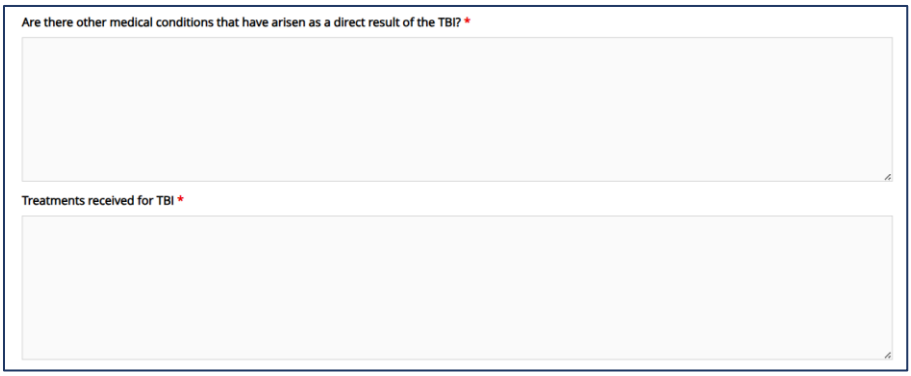


12. Enter or select a **Date TBI occurred (mm/dd).**

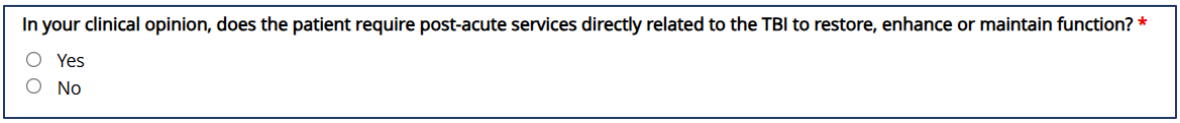


13. Enter the **Cause of TBI**.

14. Enter the required and relevant information.



15. Select **Yes**, or **No**.

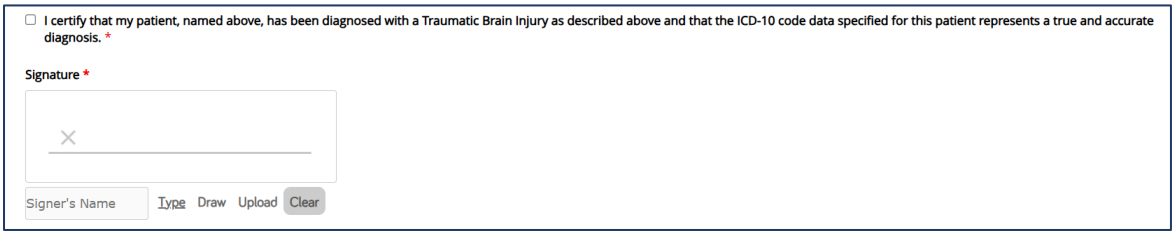


16. Select the relevant information.

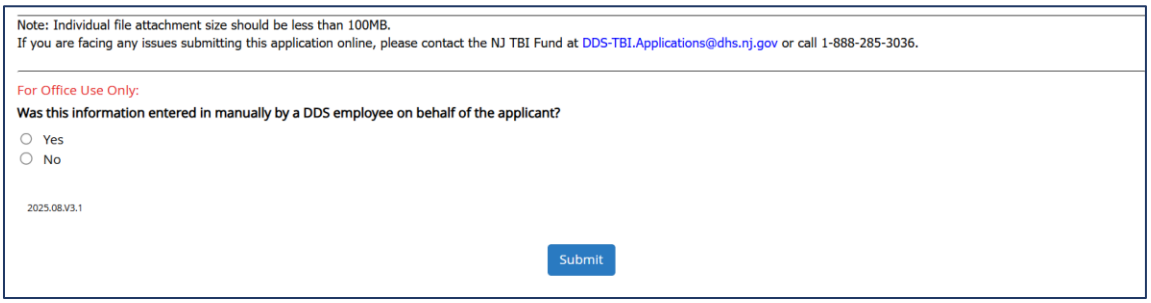
8. Enter your **Name**.

Note: The Date is automatically populated and cannot be changed.

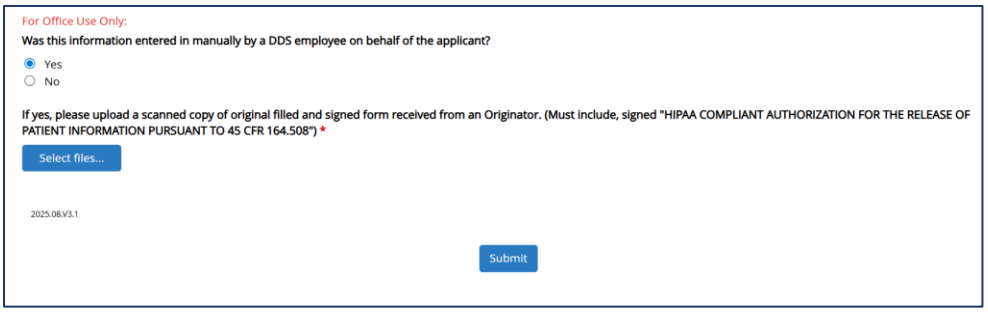
9. Read the statement and select the box if you certify.
10. **Type**, **Draw**, or **Upload** your **Signature**.



11. Review the **Note.**
12. Select **Yes**, or **No.** If you select **Yes,** please attach all the relevant files.
13. Select **Submit.**



Note: If you selected Yes, please attach the relevant files.



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