BlueShield
of Northeastern New York

Chiropractic Treatment Request Form

Please verify the member's benefits prior to submission of the CTR Form. Use blue or black ink, print one character per box.

Fax number: 1-716-887-7913

Telephone number: 1-716-884-2942 or 1-800-677-3086

1—Provider Information

Provider's NPI #

Provider's Last Name

Provider's First Name

Address

Suite

City

State

Zip

Provider's Telephone Number (include area code)

Provider's Fax Number (include area code)

2—Patient's Information

Patient's Last Name

Patient's First Name

Address

Apt **Suite**

Patient's Date of Birth (MMDDYYYY)

City

State

Zip

Patient's Member ID # **Prefix** **Number**

Patient's Telephone Number (include area code)

3—Clinical Findings

Does the patient have any Red Flags for Treatment? ○ **Yes** ○ **No**

Is this related to a: **Work Accident?** ○ **Yes** ○ **No** **Auto Accident?** ○ **Yes** ○ **No**

Is this Maintenance/Elective Care? ○ **Yes** ○ **No** **Total amount of office visits this calendar year:** ________

Primary Diagnosis

Secondary Diagnosis

In Current Benefit Year:

Date of Service: Initial Visit(MMDDYYYY)

Most Recent (MMDDYYYY)

Estimated Date of Release (MMDDYYYY)

Injury: ○ Acute ○ Sub-Acute ○ Chronic ○ Insidious ○ Traumatic

Area of Complaint: ○ **Left** ○ Cervical ○ Thoracic ○ Lumbopelvic

○ **Right** ○ Cervical ○ Thoracic ○ Lumbopelvic

Radiating Component: ○ NA

○ **Left** ○ Lower Extremity ○ Upper Extremity ○ Pain ○ Paresthesia ○ Weakness

○ **Right** ○ Lower Extremity ○ Upper Extremity ○ Pain ○ Paresthesia ○ Weakness

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Patient's Member ID # Prefix [ ][ ][ ] Number [ ][ ][ ][ ][ ][ ][ ][ ][ ]

3—Clinical Findings — continued

Range of Motion Restrictions:

◯ **Cervical**	◯ Mild	◯ Moderate	◯ Severe	◯ WNL
◯ **Thoracic**	◯ Mild	◯ Moderate	◯ Severe	◯ WNL
◯ **Lumbar**	◯ Mild	◯ Moderate	◯ Severe	◯ WNL

Functional deficit / ADL's: ◯ Mild ◯ Moderate ◯ Severe ◯ None

	Date of Visit (MMDDYYYY)	Pain Scale Score	Oswestry Low Back Score	Neck Disability Score	Roland/Morris Score
Initial Visit					
Most Recent Visit					

Neurological Findings:

◯ **Yes** ◯ **No**	Upper Extremity:	Motor Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present
		Reflex Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present
		Sensory Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present
◯ **Yes** ◯ **No**	Lower Extremity:	Motor Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present
		Reflex Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present
		Sensory Deficit	◯ Left	◯ Absent	◯ Present
			◯ Right	◯ Absent	◯ Present

Diagnostic Findings (EMG, MRI, X-ray, etc.): ◯ N/A

Prior Interventions/Treatments: ◯ N/A

Recent Surgeries/Procedures: ◯ N/A

Contributing Relevant Medical/Surgical & History Factors: ◯ N/A

4—Treatment Plan

Home Exercise Plan:
- ◯ ADL Modifications
- ◯ Heat
- ◯ Ice
- ◯ Self Management
- ◯ Therapeutic Exercises
- ◯ Other

Manual Therapy:
- ◯ Flexion/Distraction
- ◯ Manipulation
- ◯ Mobilization
- ◯ Soft Tissue
- ◯ Stretching/Strengthening
- ◯ Instrument Assisted Soft Tissue
- ◯ Other

Modalities:
- ◯ Exercises
- ◯ Heat
- ◯ Ice
- ◯ TENS/EMS
- ◯ Ultrasound
- ◯ Other

5—Provider's Signature

I certify this information accurately reflects the patient's medical record.

Provider's Signature **Date** (MMDDYYYY)

Please include additional information, if necessary.