



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

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Most Recent Visit	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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: <input type="radio"/> ADL Modifications	Manual Therapy: <input type="radio"/> Flexion/Distracton	Modalities: <input type="radio"/> Exercises
<input type="radio"/> Heat	<input type="radio"/> Manipulation	<input type="radio"/> Heat
<input type="radio"/> Ice	<input type="radio"/> Mobilization	<input type="radio"/> Ice
<input type="radio"/> Self Management	<input type="radio"/> Soft Tissue	<input type="radio"/> TENS/EMS
<input type="radio"/> Therapeutic Exercises	<input type="radio"/> Stretching/Strengthening	<input type="radio"/> Ultrasound
<input type="radio"/> Other	<input type="radio"/> Instrument Assisted Soft Tissue	<input type="radio"/> Other
	<input type="radio"/> 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.