Excellus BlueCross BlueShield
Chiropractic Treatment Plan, 2003 Revision
Instructions for Use

You may make as many copies as needed of the treatment plan form. Consider adding provider name, address, phone and fax numbers prior to copying.

1. Patient Name
2. Patient date of birth
3. Patient ID number (including prefix)
4. Patient Address
5. Patient Phone Number
6. Provider Name
7. Provider Address
8. Provider Phone#/Fax#
9. Referring Physician (full name)

NOTE: All of the above items are self-explanatory. We have tried to request only the information necessary for a review.

10. Date of initial visit. This refers to the first time the patient was ever seen in your office.

11. Indication whether new patient, new injury, exacerbation of old injury, or updated treatment plan for continued care.

12. Indication whether the treatment plan is for initial, recurrent or chronic complaint.

13. Cause of current complaint.

14. Date of exacerbation/new injury.

15. List the main working diagnoses.

16. Briefly describe the current complaint. For example, right side neck pain with numbness and tingling into the right thumb and right index finger.

17. Please remark about any contributing or relevant factors/history that may affect the outcome of the patient’s care, such as obesity, sedentary lifestyle, diabetes, or arthritis.

18. Evaluation findings – Use this table to report your findings during an evaluation. It has been designed to allow the provider to use only one treatment plan for multiple requests for care. The goal of Excellus BCBS is for less paperwork and more time available for patient care.

(continued on next page)
Remember to **always include the date of the evaluation** in the appropriate box in the top row. Include orthopedic, neurologic, diagnostic and outcome study findings in the appropriate column in each row. While we prefer to have the diagnostic reports submitted at the time of the request for care, it is not mandatory. If the reports are submitted, however, please enter the word “attached” in the column so the reviewer knows to look for them.

Please submit the actual patient questionnaire/index with all requests for care. Remember that these outcome tools are serial in nature. This means there needs to be more than one (of the same type) in order to trend the patient’s response to care. It is, therefore, very important to include a date (as well as the patient’s name) on each of these.

19. Status – post care. This section is for the provider to make an educated decision on the patient’s outcomes and response to care.

20. Treatment goals. BRIEFLY state your outcome goals for the patient based on the course of treatment.

21. Visits Requested. State the number of visits needed.

22. Time Frame for Care. State the time period (from when to when) over which the treatment will occur.

23. Any additional information. Please include any additional information that might be helpful to our utilization management staff.

24. Sign and date the copy of the treatment plan that you mail or fax to Excellus BCBS.
Excellus BlueCross BlueShield
Chiropractic Treatment Plan

Patient Name: ___________________________ DOB: _______ ID #: _______

Patient Address: ___________________________ Phone Number: ___________________________

Provider Name: ___________________________ Address: ___________________________

Phone #:/Fax #: ___________________________ Referring Physician: ___________________________

Date of initial visit: ________________________

Is this patient: □ New to office □ New injury □ Exacerbation of old injury □ Needs continued care

Is this: □ Initial complaint □ Recurrent complaint □ Chronic complaint

Cause of current complaint: □ Trauma □ Insidious □ Repetitive Injury □ Post-surgical

Date of Exacerbation/New injury: ________________________

Diagnosis: 1) __________________ 2) __________________ 3) __________________ 4) __________________

Current Complaint Description: ____________________________________________________________

Contributing Relevant Medical/Surgical and History Factors: ____________________________________________

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<td>Orthopedic Findings/ROM</td>
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Status

Post care: □ No residuals, D/C □ Residuals, D/C □ Residuals, PRN/Supportive care □ Requires cont. care □ Referred/transferred

Treatment Goals:

Visits Requested: ___________________________ Time Frame for Care: ___________________________

Any additional information:

I certify that this information accurately reflects patient’s medical record.

Provider Signature: ___________________________ Date: ___________________________

Revised 2003