

**WASHINGTON BREAST AND CERVICAL HEALTH PROGRAM
CERVICAL DIAGNOSTIC AND REIMBURSEMENT FORM**

Please Clearly Print

| | | | |
|--|----------------------------|--|--------------------------------|
| CLIENT NAME (Last, First, MI) | DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY NUMBER | DATE OF PROCEDURE (mm/dd/yyyy) |
| REFERRING CLINIC SITE | SPECIALTY CLINIC SITE | PLACE OF SERVICE <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ASC | WBCHP CLIENT ID # |
| Referred for diagnostic evaluation by non-BCHP provider on: (mm/dd/yyyy) | SPECIALTY PROVIDER NAME | | |

PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO WBCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)

Name of insurance company _____ Policy / Identification number _____

| | | |
|-------------------------------|---|---|
| Procedures and Results | <input type="checkbox"/> Colposcopy Result _____ | <input type="checkbox"/> LEEP Result _____ |
| | <input type="checkbox"/> Colposcopy with biopsy(s) Result _____ | <input type="checkbox"/> EMB..... Result _____ |
| | <input type="checkbox"/> Conization of cervix Result _____ | <input type="checkbox"/> Cone (cold or laser) Result _____ |
| | <input type="checkbox"/> Colposcopy with endo curet..... Result _____ | <input type="checkbox"/> Endometrial curet Result _____ |
| | <input type="checkbox"/> Colposcopy with LEEP with bx Result _____ | |
| | <input type="checkbox"/> Colposcopy with LEEP with cone Result _____ | |

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|-----------------------------------|---|--|
| Final Diagnosis and Status | <input type="checkbox"/> Normal/Benign reaction/inflammation <input type="checkbox"/> HPV / Condylomata / Atypia <input type="checkbox"/> CIN I / mild dysplasia <input type="checkbox"/> CIN II / moderate dysplasia <input type="checkbox"/> CIN III / severe dysplasia / Carcinoma in situ (Stage 0) <input type="checkbox"/> Invasive Cervical Carcinoma <input type="checkbox"/> Other (specify) _____ | AJCC Stage at Diagnosis (For invasive cervical carcinoma only) Stage grouping _____ (1 – 4) |
|-----------------------------------|---|--|

| | |
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| Final Diagnosis and Status | <input type="checkbox"/> Work-up complete date: _____ <input type="checkbox"/> Work-up pending date: _____ Why Pending _____ <input type="checkbox"/> *Lost to follow-up date: _____ Why Lost _____ <input type="checkbox"/> *Work-up refused date: _____ Why Refused _____ <p align="center">* Provide documentation to WBCHP Prime Contractor of attempts to contact client</p> |
|-----------------------------------|--|

| | |
|----------------------------|--|
| Status of Treatment | <input type="checkbox"/> TX recommended date: _____ <input type="checkbox"/> Conization <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> LEEP <input type="checkbox"/> TX started date: _____ <input type="checkbox"/> Conization <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> LEEP <input type="checkbox"/> *Lost to follow-up date: _____ Why Lost _____ <input type="checkbox"/> *TX refused date: _____ Why Refused _____ <p align="center">* Provide documentation to WBCHP Prime Contractor of attempts to contact client</p> |
|----------------------------|--|

If referred for treatment, treatment clinical site/provider: _____

| | | |
|------------------------|--|--|
| Services Billed | <u>Office/Consultation Visit</u> <input type="checkbox"/> 99213 – Detail est <input type="checkbox"/> 99241 – 15 min <input type="checkbox"/> 99242 – 30 min <input type="checkbox"/> 99243 – 40 min <u>Laboratory</u> <input type="checkbox"/> 88305 – Bx interpret <input type="checkbox"/> 88307 – Bx interpret <input type="checkbox"/> 88342 – Immunohistochemistry | <u>Procedures</u> <input type="checkbox"/> 57452 – Colpo <input type="checkbox"/> 57454 – Colpo w/ bx cx & endo curet <input type="checkbox"/> 57455 – Colpo w/ bx cx <input type="checkbox"/> 57456 – Colpo w/ endo curet <input type="checkbox"/> 57460 – Colpo w/ LEEP w/ bx <input type="checkbox"/> 57461 – Colpo w/ LEEP w/ cone <input type="checkbox"/> 57500 – Bx cx <input type="checkbox"/> 57505 – Endo curet <input type="checkbox"/> 57520 – Cone cx <input type="checkbox"/> 57522 – LEEP <input type="checkbox"/> 58110 – Endometrial bx done w/colpo |
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DIAGNOSTIC PROVIDER SIGNATURE/TELEPHONE NUMBER _____ Date _____

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