

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

Please Print Clearly

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 _____			
<b>Procedures and Results</b>	<input type="checkbox"/> <b>Surgical Consult / Repeat Breast Exam</b> Result _____ Recommendation _____				
	<input type="checkbox"/> <b>Ultrasound</b>	<input type="checkbox"/> Neg <input type="checkbox"/> Highly Suggest Malig	<input type="checkbox"/> Benign <input type="checkbox"/> Assess Incomplete	<input type="checkbox"/> Probably Benign <input type="checkbox"/> Tech Unsatisfactory	<input type="checkbox"/> Suspicious Abnormality
	<input type="checkbox"/> <b>Biopsy</b>	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt
	<input type="checkbox"/> <b>FNA</b>	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt
	<input type="checkbox"/> <b>Cyst Aspiration</b>	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt
	<input type="checkbox"/> <b>Ducto/Galactogram</b>	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp	<input type="checkbox"/> Non-Diag / Needs rpt
<b>Final Diagnosis and Status</b>	<input type="checkbox"/> Not Cancer		<input type="checkbox"/> Lobular Carcinoma In Situ		
	<input type="checkbox"/> Atypical Hyperplasia		<input type="checkbox"/> Ductal Carcinoma In Situ		
			<input type="checkbox"/> Cancer Invasive		
	<b>AJCC Stage at Diagnosis</b> (For invasive cancer only) Stage grouping _____ (1 – 4) Tumor Size _____ cm				
<b>Status of Treatment</b>	<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 _____				
<b>* Provide documentation to WBCHP Prime Contractor of attempts to contact client</b>					
<b>Services Billed</b>	<input type="checkbox"/> Treatment recommended – Date _____				
	<input type="checkbox"/> Lumpectomy		<input type="checkbox"/> Modified Mastectomy		
	<input type="checkbox"/> Axillary Dissection		<input type="checkbox"/> Sentinel Node Biopsy		
	<input type="checkbox"/> Radical Mastectomy		<input type="checkbox"/> Radiation		
<input type="checkbox"/> Endocrine Therapy					
<input type="checkbox"/> Treatment started – Date _____				<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Lumpectomy				<input type="checkbox"/> Radiation	
<input type="checkbox"/> Modified Mastectomy				<input type="checkbox"/> Endocrine Therapy	
<input type="checkbox"/> Radical Mastectomy					
<input type="checkbox"/> *Lost to follow-up – Date _____ ..... Why Lost _____					
<input type="checkbox"/> *Treatment refused – Date _____ ..... Why Refused _____					
<b>* Provide documentation to WBCHP Prime Contractor of attempts to contact client</b>					
If referred for treatment, treatment clinical site/provider: _____					
<b>Services Billed</b>	<b>Office/Consultation Visit</b>				
	<input type="checkbox"/> 99213 – Detail est		<input type="checkbox"/> 99242 – 30 min		
	<input type="checkbox"/> 99241 – 15 min		<input type="checkbox"/> 99243 – 40 min		
	<b>Procedures</b>				
	<input type="checkbox"/> 10021 – FNA w/o image				
	<input type="checkbox"/> 10022 – FNA w/ image				
	<input type="checkbox"/> 19000 – Drng brst lesion				
	<input type="checkbox"/> 19001 – Drng brst lesion add				
	<input type="checkbox"/> 19030 – Injec brst x-ray				
	<input type="checkbox"/> 19100 – Bx brst perc w/o image				
<input type="checkbox"/> 19101 – Bx brst open					
<input type="checkbox"/> 19102 – Bx brst perc w/ image					
<input type="checkbox"/> 19103 – Bx brst perc w/ device					
<b>Services Billed</b>	<b>Procedures (cont'd)</b>				
	<input type="checkbox"/> 19120 – Rmv brst lesion				
	<input type="checkbox"/> 19125 – Exc brst lesion				
	<input type="checkbox"/> 19126 – Exc brst lesion add				
	<input type="checkbox"/> 19290 – Place ndl wire brst				
	<input type="checkbox"/> 19291 – Place ndl wire brst add				
	<input type="checkbox"/> 19295 – Place brst clip perc				
	<b>Imaging</b>				
	<input type="checkbox"/> 77031 – Stereo brst bx ea lesion				
	<input type="checkbox"/> 77032 – X-ray ndl wire brst				
<input type="checkbox"/> 77053 – Ducto or galactogram					
<input type="checkbox"/> 77054 – Ducto or galactogram multip					
<input type="checkbox"/> 77055 or <input type="checkbox"/> G0206 – Mammo uni					
<input type="checkbox"/> 77056 or <input type="checkbox"/> G0204 – Mammo bilat					
<b>Services Billed</b>	<b>Imaging (cont'd)</b>				
	<input type="checkbox"/> 76098 – X-ray brst spec				
	<input type="checkbox"/> 76645 – Us brst				
	<input type="checkbox"/> 76942 – Echo guide bx				
	<b>Laboratory</b>				
	<input type="checkbox"/> 88108 – Cytopath conc tech				
	<input type="checkbox"/> 88172 – Cytopath eval, fna				
	<input type="checkbox"/> 88173 – Cytopath eval, fna, report				
	<input type="checkbox"/> 88305 – Bx interpret				
	<input type="checkbox"/> 88307 – Bx interpret				
<input type="checkbox"/> 88331 – Tissue block froz, first					
<input type="checkbox"/> 88332 – Tissue block froz, add					
<input type="checkbox"/> 88342 – Immunohistochemistry					
DIAGNOSTIC PROVIDER SIGNATURE/TELEPHONE NUMBER _____					
				Date _____	

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