

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	CHART NUMBER
Referred for diagnostic evaluation by non-BCCHP provider on: (mm/dd/yyyy)		SPECIALTY PROVIDER NAME		
Procedures and Results	<input type="checkbox"/> Surgical Consult / Repeat Breast Exam Result _____ Recommendation _____			
	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Neg <input type="checkbox"/> Highly Suggest Malig	<input type="checkbox"/> Benign <input type="checkbox"/> Probably Benign <input type="checkbox"/> Assess Incomplete	<input type="checkbox"/> Suspicious Abnormality <input type="checkbox"/> Tech Unsatisfactory
	<input type="checkbox"/> Biopsy	<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"/> No Specimen
	<input type="checkbox"/> FNA	<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"/> No Specimen
	<input type="checkbox"/> Cyst Aspiration	<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"/> No Specimen
	<input type="checkbox"/> Ducto/Galactogram	<input type="checkbox"/> Neg Malig	<input type="checkbox"/> Pos Malig	<input type="checkbox"/> Indeterm/ Atyp <input type="checkbox"/> Non-Diag / Needs rpt
Final Diagnosis and Status	<input type="checkbox"/> Not Cancer <input type="checkbox"/> Lobular Carcinoma In Situ* <input type="checkbox"/> Ductal Carcinoma In Situ* <input type="checkbox"/> Cancer Invasive* <input type="checkbox"/> Atypical Hyperplasia* <i>*If diagnosed with any of these diagnoses, please contact BCCHP to enroll onto DSHS through the Breast and Cervical Treatment Program for treatment.</i>			
	<input type="checkbox"/> Work-up complete – Date _____ Recommended follow-up _____			
	<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 _____				
** Provide documentation to BCCHP Prime Contractor of attempts to contact client				
Status of Treatment	<input type="checkbox"/> Treatment recommended – Date _____			
	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Modified Mastectomy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation			
	<input type="checkbox"/> Axillary Dissection <input type="checkbox"/> Sentinel Node Biopsy <input type="checkbox"/> Radical Mastectomy <input type="checkbox"/> Endocrine Therapy			
	<input type="checkbox"/> Treatment started – Date _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation			
	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Modified Mastectomy <input type="checkbox"/> Radical Mastectomy <input type="checkbox"/> Endocrine Therapy			
	<input type="checkbox"/> **Lost to follow-up – Date _____ Why Lost _____			
<input type="checkbox"/> **Treatment refused – Date _____ Why Refused _____				
** Provide documentation to BCCHP Prime Contractor of attempts to contact client				
If referred for treatment, treatment clinical site/provider: _____				
Services Billed	Office Visit <input type="checkbox"/> 99212 – Detail est <input type="checkbox"/> 99214 – Detail est <input type="checkbox"/> 99213 – Detail est <input type="checkbox"/> 99215 – Detail est		Procedures (cont'd) <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	
	Procedures <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 <input type="checkbox"/> 19120 – Rmv brst lesion		Imaging <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 <input type="checkbox"/> 76098 – X-ray brst spec	
			Imaging (cont'd) <input type="checkbox"/> 76645 – Us brst <input type="checkbox"/> 76942 – Echo guide bx	
			Laboratory <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 _____	
	PLEASE PRINT NAME HERE			

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PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 667-7352