

CLIENT NAME (Last, First, MI)	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	DATE OF PROCEDURE (mm/dd/yyyy)
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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"/> Biopsy Result _____	<input type="checkbox"/> LEEP* Result _____
	<input type="checkbox"/> Colposcopy Result _____	<input type="checkbox"/> EMB Result _____
	<input type="checkbox"/> Colposcopy with biopsy(s) Result _____	<input type="checkbox"/> Cone*(cold or laser).... Result _____
	<input type="checkbox"/> Conization of cervix Result _____	<input type="checkbox"/> Endocervical curetting . Result _____
	<input type="checkbox"/> Colposcopy with endo curet..... Result _____	<input type="checkbox"/> Consultation..... Result _____
	<input type="checkbox"/> Colposcopy with LEEP with bx Result _____	
	<input type="checkbox"/> Colposcopy with LEEP with cone Result _____	
	<i>*Must obtain pre-approval from Prime Contractor prior to procedure.</i>	

Final Diagnosis and Status	<input type="checkbox"/> Normal/Benign reaction/inflammation	<input type="checkbox"/> CIN III / severe dysplasia / Carcinoma in situ (Stage 0)**
	<input type="checkbox"/> HPV / Condylomata / Atypia	<input type="checkbox"/> Invasive Cervical Carcinoma**
	<input type="checkbox"/> CIN I / mild dysplasia**	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> CIN II / moderate dysplasia**	
<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>		

Final Diagnosis and Status	<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"/> 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 _____				
*** Provide documentation to BCCHP Prime Contractor of attempts to contact client						

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

Services Billed	Office/Consultation Visit		Lab – cont.	Procedures
	<input type="checkbox"/> 99212 – Detail est	<input type="checkbox"/> 99214 – Detail est	<input type="checkbox"/> 57452 – Colpo	<input type="checkbox"/> 57500 – Bx cx
	<input type="checkbox"/> 99213 – Detail est	<input type="checkbox"/> 99215 – Detail est	<input type="checkbox"/> 57454 – Colpo w/ bx cx & endo curet	<input type="checkbox"/> 57505 – Endo curet
	<input type="checkbox"/> 99204 – Detail new	<input type="checkbox"/> 99205 – Detail new	<input type="checkbox"/> 57455 – Colpo w/ bx cx	<input type="checkbox"/> 57520 – Cone cx
Laboratory		<input type="checkbox"/> 57456 – Colpo w/ endo curet	<input type="checkbox"/> 57522 – LEEP	
<input type="checkbox"/> 88305 – Bx interpret		<input type="checkbox"/> 57460 – Colpo w/ LEEP w/ bx	<input type="checkbox"/> 58110 – Endometrial bx done w/colpo	
<input type="checkbox"/> 88307 – Bx interpret		<input type="checkbox"/> 57461 – Colpo w/ LEEP w/ cone		
<input type="checkbox"/> 88342 – Immunohistochemistry				

DIAGNOSTIC PROVIDER SIGNATURE

_____ Date _____

Please Print Name Here

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PLEASE FAX TO BCCHP PRIME CONTRACTOR: _____