

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"/> 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 _____		<i>*Must obtain pre-approval from Prime Contractor prior to procedure.</i>	
	<input type="checkbox"/> Colposcopy with LEEP with cone Result _____			
	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>				
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 Visit		Lab – cont.	
	<input type="checkbox"/> 99212 – Detail est <input type="checkbox"/> 99214 – Detail est		<input type="checkbox"/> 57454 – Colpo w/ bx cx & endo curet	
	<input type="checkbox"/> 99213 – Detail est <input type="checkbox"/> 99215 – Detail est		<input type="checkbox"/> 57455 – Colpo w/ bx cx	
Laboratory		<input type="checkbox"/> 57456 – Colpo w/ endo curet		
<input type="checkbox"/> 88305 – Bx interpret		<input type="checkbox"/> 57460 – Colpo w/ LEEP w/ bx		
<input type="checkbox"/> 88307 – Bx interpret		<input type="checkbox"/> 57461 – Colpo w/ LEEP w/ cone		
<input type="checkbox"/> 88342 – Immunohistochemistry				
<input type="checkbox"/> 57452 – Colpo				
		Procedures		
		<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		
DIAGNOSTIC PROVIDER SIGNATURE				
_____				Date _____
Please Print Name Here				

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PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 324-1408