


**RADIOLOGY
BREAST EVALUATION
REPORTING AND REIMBURSEMENT FORM**

Please Print Clearly

REFERRAL SOURCE	CLIENT NAME (Last, First, MI)		DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	DATE OF PROCEDURE (mm/dd/yyyy)	
	RADIOLOGY FACILITY/SITE		PREVIOUS RADIOLOGY FACILITY/DATE (COMPARISON)*	CHART NUMBER		
	REFERRING CLINIC SITE			REFERRING PROVIDER NAME		
	PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO BCCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)					
	Name of insurance company _____			Policy/Identification number _____		
Ordering Clinician's Remarks: _____ _____ _____			Right  Left			

FOR RADIOLOGY / MAMMOGRAPHY FACILITY USE ONLY BELOW THIS LINE

A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE.
Palpable breast masses need to be evaluated clinically and/or with additional imaging regardless of mammogram result.

Mammography / Ultrasound Bi-Rads Results	Mam	US	
	<input type="checkbox"/>	<input type="checkbox"/>	(1) Negative – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present.
	<input type="checkbox"/>	<input type="checkbox"/>	(2) Benign – There is nothing to suggest cancer; however there are benign findings that warrant reporting. No evidence of malignancy.
	<input type="checkbox"/>	<input type="checkbox"/>	(3) Probably Benign – Short Interval Follow-up Suggested – A finding in this category has a high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would like to document its stability.
	<input type="checkbox"/>	<input type="checkbox"/>	(4) Suspicious Abnormality – These lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy.
	<input type="checkbox"/>	<input type="checkbox"/>	(5) Highly Suggestive of Malignancy – These lesions have a high probability of malignancy.
	<input type="checkbox"/>	<input type="checkbox"/>	(0) Assessment is Incomplete – Need additional evaluation. (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed. When awaiting old mammographic films to compare with current films, DO NOT assign a result of Assessment Incomplete. Instead, check the box below indicating "obtain prior films for comparison.")
	<input type="checkbox"/>	<input type="checkbox"/>	Technically Unsatisfactory – Could not be interpreted (needs to be repeated)
Recom- mendations	<input type="checkbox"/> Additional Mammographic Views <input type="checkbox"/> Ultrasound <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Biopsy		<input type="checkbox"/> Surgical Consult / Repeat Breast Exam <input type="checkbox"/> Short Interval Follow-up Suggested in _____ months <input type="checkbox"/> Routine Screening Mammogram <input type="checkbox"/> Obtain Prior Films for Comparison*
Comments			
Services Billed	<input type="checkbox"/> 77055 – Diagnostic – Unilateral mammogram <input type="checkbox"/> 77056 – Diagnostic – Bilateral mammogram <input type="checkbox"/> G0204 – Diagnostic Digital mammogram – Bilateral <input type="checkbox"/> G0206 – Diagnostic Digital mammogram – Unilateral		<input type="checkbox"/> 77057 – Screening mammogram <input type="checkbox"/> 76645 – Ultrasound of breast <input type="checkbox"/> G0202 – Screening Mammogram - Digital

RADIOLOGIST SIGNATURE:

PLEASE PRINT NAME HERE

Date: _____

CPT® codes and descriptions only are © 2009 American Medical Association.

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