SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Best Chance Network Screening/Billing Form

________________________ Authorization Number

Service Date: _____/_____/________ (MM DD YYYY)

Chart Number: __________________

Type of Visit: ☐ Routine (New BCN Client or Annual Rescreen) (CPT_______________)*
☐ Re-Visit (counseling or repeat Pap smear or symptoms between routine screening visits) (CPT_______________)*
☐ Report Only

(CMS-1500 MUST BE SUBMITTED WITH FORM)

*Enter billed CPT code to appropriate line.

(Place Provider Label Here)

Provider FTN:
Contract Facility Name:
Clinic Name:
Provider Code:

A. Client Data

Name: ______________________________________ (Last) (First) (Middle) Date of Birth: ____/____/_______ (MM DD YYYY)

Address: ______________________________________ (Street or PO Box) (City) (State) (Zip Code)

Social Security Number (last four digits): ______________________ Phone: (________)________-____________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

United States Citizen: (Does NOT Impact eligibility) ☐ Yes ☐ No

Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Asian ☐ Pacific Islander ☐ Native American

Income:
☐ Weekly ☐ Monthly ☐ Annual
$ ___________________________

Household Size (including self):

Insurance: ☐ Yes ☐ No If Yes: ☐ Diagnostic coverage <100%
☐ High deductible (>$1,000) ☐ Medicare Part A ☐ Medicaid Family Planning

Cost Explanation and Privacy Notice signed:
☐ Yes ☐ No

Is client a smoker or tobacco user? ☐ No ☐ Yes
If yes, was client referred to the SC Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669)? ☐ Yes ☐ Yes, client refused ☐ No

Was client referred to the Health Insurance Marketplace? ☐ Yes ☐ No ☐ Exempt (Have limited income.)

B. Breast Screening Data

High Risk for Breast Cancer: ☐ Yes ☐ No ☐ Not Assessed

Breast Symptoms? ☐ Yes ☐ No

Prior Mammogram? ☐ Yes ☐ No Date: ____/____/_______ (MM DD YYYY)

CBE Result: **(required for payment)** Date ____/____/_______
☐ Normal ☐ Benign findings, NOT suspicious for cancer ☐ ***Abnormal**
☐ ***Discrete palpable mass, suspicious for cancer**
☐ ***Suspicious nipple discharge**
☐ ***Nipple or areolar scaliness**
☐ ***Skin dimpling, retraction or thickening**

***Requires referral for diagnostic mammogram and ultrasound**

Initial Mammogram Indicator
☐ Screening
☐ Diagnostic
☐ Non-program mammogram, CBE only, Referred in for diagnostic evaluation
☐ No mammogram, Direct to diagnostics for short-term follow-up
☐ No Breast Service
☐ Unknown

C. Cervical Screening Data

High Risk for Cervical Cancer: ☐ Yes ☐ No ☐ Not Assessed

Prior Pap Smear? ☐ Yes Date ____/____/_______ (MM DD YYYY) ☐ No

Hysterectomy? ☐ Yes Date ____/____/_______ (MM DD YYYY) ☐ No

Cervix present ☐ Yes ☐ No

Hysterectomy Reason: ☐ Cervical Cancer ☐ CIN2/CIN3
☐ Unknown ☐ Not for cervical cancer
☐ Other ____________________________

Pelvic Exam Result: (Bill 990PN or 991PN if Pelvic Exam not performed.)
☐ Normal
☐ Abnormal – NOT suspicious for cervical cancer
☐ Abnormal – suspicious for cervical cancer (requires follow up)
☐ Abnormal peri or postmenopausal bleeding
☐ Client Refused ☐ Provider did not offer
☐ Delayed Date____/____/_______ (MM DD YYYY)

C. Cervical Screening Data cont.

Pap Test Indicator
☐ Screening
☐ Surveillance
☐ Non-program Pap, Referred in for diagnostic evaluation
☐ Pap after primary HPV+
☐ No Pap
☐ No Cervical Service

Pap Test Results: Pap Test Date ____/____/_______
☐ Negative for intraepithelial lesion or malignancy
☐ Infection/Inflammation/Reactive Changes
☐ ASC-US
☐ Low Grade SIL
☐ High Grade SIL
☐ ASC-H
☐ Squamous Cell Carcinoma
☐ Atypical Glandular Cells
☐ Adenocarcinoma in situ (AIS)
☐ Adenocarcinoma
☐ Other

HPV Test Indicator
☐ Co-Test or Screening ☐ Reflex ☐ Test Not Done

HPV Test Result HPV Test Date __/__/___
☐ Positive with positive genotyping (types 16 or 18)
☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
☐ Positive with genotyping not done
☐ Negative

D. Counseling **Counseled Time:** ☐ **<25min** ☐ **≥25min**

☐ Abnormal Breast Diagnosis ☐ Abnormal Mammogram ☐ Abnormal Pap Smear/HPV/Endometrial Biopsy ☐ Abnormal U/S, Additional Views, MRI
☐ Biopsy by Radiologist ☐ Medicaid Application

E. Patient Navigation **Fax within 48 hours referral to BCN PA Line 1-866-297-6814**

Patient Navigation Needed: ☐ No ☐ Yes: Referred to in-house patient navigation ☐ Yes: Referred to BCN patient navigation Referral date: ____/____/_____

Form Completed By: ______________________________ Date Completed: ____________________

Best Chance Network Clinical and Billing Form Instructions on Completion

PLEASE PRINT CLEARLY

1) COMPLETE AND SUBMIT THIS FORM WHEN A BCN CLIENT RECEIVED SERVICES.

Authorization Code:	Enter the client's prior authorization (PA) code issued by DPH.
Service Date:	Enter the date of the routine or revisit screenings.
Type of Visit:	Check the type of visit.
Chart Number:	Enter your facility's client record number.
Provider Label:	Please attach the provider label provided by BCN or completely fill in required information.
A. Client Data:	Complete Name, DOB, Address, last four digits of Social Security Number, Phone Number, Ethnicity, Citizenship, Race, Income, and Household Size for All Routine and Annual Revisit screenings and insurance coverage. Indicate if cost explanation form and DPH privacy notice is signed by the client. Indicate conditions limiting activity.
Tobacco Status:	Enter client's tobacco use status. The Quitline referral box should only be checked when: the patient is ready to quit smoking or using tobacco and agrees to have the Quitline call her; and the provider completes the Quitline fax referral form (1617-ENG-DPH), faxes referral form to the Quitline,places referral form in the patient's medical record, and instructs the patient that the signed Quitline referral form is her telephone appointment with the Quitline.
Health Insurance Marketplace Referral:	Check appropriate box regarding referral to the Marketplace for assessment of eligibility for subsidized Marketplace health coverage. Eligible clients (those above 100% of the federal policy level) are referred to the Marketplace by directly connecting them with Marketplace consumer assistance staff (1-800-318-2596) or providing written contact information to community consumer assistance organizations. Eligible clients include lawfully present immigrants.
B. Breast Screening Data:	Check appropriate boxes regarding Risk Assessment, Breast Symptoms, Prior Mammogram. Complete Clinical Breast Exam CBE Results, and Follow-up services. If applicable, indicate the date of refusal for any required follow-up or the date the client was determined to be lost to follow-up.
C. Cervical Screening Data:	Check appropriate boxes regarding Risk Assessment, Prior Pap Smears, Hysterectomy, Pelvic Exam Results, Pap, HPV Test, and endometrial biopsy results. If client is not due for Pap/HPV testing but pelvic exam result is abnormal suspicious for cervical cancer, then BCN will cover allowable charges for Pap/HPV. If client presents with abnormal peri or postmenopausal bleeding, and you are contracted with BCN to perform endometrial biopsy, then this can be performed on same day. Otherwise, please refer to a BCN cervical follow-up provider. If applicable, indicate the date of referral for any required follow-up, the date that the client was determined to be lost to follow-up or refused follow-up.
D. Counseling:	Check all appropriate boxes. CPT code for counseling should be billed on CMS-1500.
E. Patient Navigation:	Complete if client assessment indicates need for BCN patient navigation and meets guidelines for referral. Enter date of patient navigation referral. Person completing patient navigation referral form signs and dates.
F. Certification:	Sign and date the form. The person signing accepts the following: I certify under penalty of perjury that the information I have provided as an authorized, contracted provider for Best Chance Network (BCN) medical services has been obtained and verified. I understand the information I provide will be used to determine the patient's eligibility for Best Chance Network (BCN) medical services. I understand that as a contracted provider of these services, SC Department of Public Health (SC DPH) can audit or request any eligibility or supporting documents, to verify that the patient meets the eligibility requirements.

Print the name of the person completing the form and the date the form is completed.

Mail completed forms and reports to:
DPH
Best Chance Network
2100 Bull Street
Columbia, SC 29201

Note: Please call your BCN Regional Provider Coordinator if you have any questions regarding completing this form or coverage of services.

Office Mechanics & Filing:	Forms are submitted to DPH for data entry and reimbursement. Retain this signed form in the record for six years after the contract expiration date. BCN records shall be available for audit.