SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Best Chance Network Breast Follow-up/Billing Form

______________________ Authorization Number (required)

Service Date: _____/_____/_______ (MM DD YYYY) Chart Number: _______

(Provider Label may be placed here)

Provider FTN:

Contract Facility Name: Clinic Name:

Provider Code:

Type of Visit: ☐ First BCN Visit to this office

→ Referred by:__________________

☐ Follow-up Visit (includes counseling)

☐ Report Only/Non BCN Funded Services

A. CLIENT DATA

Name: ________________________________ (Last) (First) (Middle) Date of Birth: ______/_____ /______ (MM DD YYYY)

SSN (Last four digits) OR Med-IT ID: ______________________________

B. BREAST FOLLOW-UP

Clinical Breast Exam Results (By Surgeon): ☐ Surgical consult ☐ Post Dx/Tx Normal

☐ Normal ☐ Discrete Palpable Mass ☐ Suspicious Nipple Discharge

☐ Benign ☐ Nipple or Areola Scaliness ☐ Skin Dimpling or Retraction

☐ Wound Check (Post Dx/Tx)

Check the following procedures if reports are attached:

Pathology Reports (Please attach CMS 1500)

☐ Breast Cyst Aspiration

☐ Breast Biopsy

☐ Other: ______________________

Radiology Reports (Please attach CMS 1500)

☐ Breast MRI

☐ Diagnostic Mammogram

☐ Ultrasound

☐ Other:______________________

Further Work Up Needed? ☐ Yes ☐ No ☐ Refused _____/_____/_______ ☐ Lost To Follow-up _____/_____/_______

Procedure(s)	Date (MM/DD/YYYY)
☐ Breast MRI	_____/_____/_______
☐ Repeat CBE	_____/_____/_______
☐ Breast Cyst Aspiration	_____/_____/_______
☐ Ultrasound	_____/_____/_______
☐ Breast Biopsy	_____/_____/_______
☐ Other	_____/_____/_______

C. FINAL DIAGNOSIS

Date of Final Diagnosis: ___/___/_____

Final Diagnosis Status

☐ Work-up complete

☐ Work-up pending

☐ Lost to follow-up

☐ Work-up refused

☐ Irreconcilable

Final Diagnosis

☐ Carcinoma in Situ, Other*

☐ Invasive Breast Cancer

☐ Breast Cancer Not Diagnosed

☐ Lobular Carcinoma in Situ (LCIS) - (Stage 0)

☐ Ductal Carcinoma in Situ (DCIS) - (Stage 0)

D.TREATMENT

Treatment:	Date(MM/DD/YYYY)
☐ Started on:	_____/_____/_______
☐ Refused on:	_____/_____/_______
☐ Lost to Follow-up on:	_____/_____/_______

Treatment Type:

☐ Lumpectomy ☐ Chemotherapy

☐ Mastectomy ☐ Other:____________

☐ Radiation Therapy

E. COUNSELING

Counseled Time: ☐ <25min ☐ ≥25min

☐ Abnormal Diagnostic Test(s) ☐ Treatment Options ☐ Medicaid Application

Form Completed By: ______________________________ **Date:**_____/_____/_______ (MM DD YYYY)

Best Chance Network Breast Follow-Up/Billing Form
Instructions for Completing 1013-ENG-DPH

Service Date: Enter month, day and year.

Chart Number: Optional for provider use. For client's chart number at provider office.

Type of Visit: Mark appropriate box. If new patient, list referring provider.

Provider Label: A provider label must be attached to receive reimbursement for allowable BCN services.

Name: Enter last name, and first name.

Date of Birth: Enter month, day and year.

Med-IT ID or SSN: Enter the unique identifier for client.

Clinical Breast Exam: If performed at this visit, mark the appropriate box.

Radiology Reports: If performed and attached, mark appropriate box.

Pathology Reports: If performed and attached, mark appropriate box.

Further Work Up Needed: Mark appropriate box. If "yes," mark the appropriate boxes under procedures and complete date (month, day and year) procedure is expected to be performed.

List the facility where follow-up services will be performed: Give facility name where client is receiving further work-up.

Treatment: Mark appropriate box. If started, complete date (month, day and year) treatment started.

Treatment Type: If treatment started, mark appropriate box.

Counseling: Mark appropriate box if client returned to discuss abnormal results, treatment options or to complete Medicaid application.

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) and 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.

Form Completed by: Give name, title and date.

Mail completed forms and reports to:
DPH
Cancer Prevention & Control
2100 Bull Street
Columbia, SC 29201

Office Mechanics: Original to BCN and one copy for patient's medical chart.

Retention Schedule: BCN records shall be retained by the Provider for 6 years after the end of the contract and shall be available for audit and inspection at any time such audit is deemed necessary by DPH.