Best Chance Network
Cervical Follow-up/Billing Form

3. Provider Site Label:

1. Service Date ____-____-________ (MM DD YYYY) Chart # ___________

(Please attached CMS 1500)

2. Type of Visit: ☐ First BCN Visit to this office (CPT 99203) ☐ Follow-up Visit (including counseling) (CPT 99213) ☐ Report Only/Non-BCN Funded Services

A. PATIENT INFORMATION (Please Print Clearly)

4. Name: ________________________ (Last) ________________________ (First)
5. Birthdate: ____-____-______ (MM DD YYYY)
6. SSN (Last four digits):______________________ OR Med-IT ID:______________________

B. PELVIC EXAM & PAP SMEAR RESULTS

7. **Pelvic Exam Results:**
   - ☐ Not performed at this visit
   - ☐ Abnormal peri or postmenopausal bleeding
   - ☐ Normal ☐ Abnormal - not suspicious for CIN or cancer
   - ☐ Abnormal - suspicious for CIN or Cervical Cancer

8. **Pap performed at this visit:**
   - ☐ Yes ☐ No Pap
   - ☐ Yes ☐ No HPV Date: ____/____/_______
   - ☐ Yes ☐ No HPV 16 & 18 Date: ____/____/_______

9. **Pap Smear Results (Bethesda 2002)**
   - ☐ Negative for Intraepithelial Lesion or Malignancy
   - ☐ Atypical Squamous Cells of Undetermined Significance (ASC-US) (may test for HPV DNA)
   - ☐ Low-Grade Squamous Intraepithelial Lesions including (HPV & CIN I) (may require follow-up)
   - ☐ Atypical Squamous Cells, cannot exclude High-Grade SIL (ASC-H)
   - ☐ High-Grade Squamous Intraepithelial Lesions: Moderate & Severe Dysplasia: CIS, CIN2 and CIN3
   - ☐ Squamous Cell Carcinoma
   - ☐ Abnormal Glandular Cells
   - ☐ Adenocarcinoma in situ ☐ Adenocarcinoma
   - ☐ Other (specify) ______________________

10. **HPV Test Indicator:**
   (☐ Co-Test/Screening ☐ Reflex ☐ Test Not Done)
   - ☐ Positive with positive genotyping (types 16 or 18)
   - ☐ Positive with negative genotyping (positive HPV, bu tnot types 16 or 18)
   - ☐ Positive with genotyping not done
   - ☐ Negative

C. CERVICAL FOLLOW UP (Please attach CMS 1500)

11. **Type of Procedures Performed and Date** ____/___/_____
   - ☐ Colposcopy of Cervix without Biopsy (CPT 57452)
   - ☐ Colposcopy of Cervix with Biopsy(s) of Cervix (CPT 57455)
   - ☐ Colposcopy of Cervix with Biopsy of Cervix and Endocervical Currettage (CPT 57454)
   - ☐ Colposcopy of Cervix with Endocervical Currettage (CPT 57456)
   - ☐ Endocervical currettage (CPT 57505)
   - ☐ Endometrial sampling (CPT 58100)
   - ☐ Endometrial sampling with Colposcopy (CPT 58110)
   - ☐ LEEP (CPT 57522)
   - ☐ Conization (CPT 57461)
   - ☐ Polyp Excision (CPT 57500)
   - ☐ Vaginal Biopsy without Cervix Present (CPT 57100)

12. **Procedures Results**
   - ☐ Normal/Benign/Inflammation
   - ☐ HPV/Condyloma/Atypia
   - ☐ CIN I – Mild Dysplasia
   - ☐ CIN II Moderate Dysplasia based on Biopsy
   - ☐ CIN III Severe Dysplasia/Carcinoma in situ based on biopsy
   - ☐ Squamous Cell Cancer based on Biopsy
   - ☐ Adenocarcinoma based on biopsy
   - ☐ Unsatisfactory
   - ☐ Other (specify) ____________________

13. **Biopsy Report(s) Attached** ☐ Yes ☐ No

C. CERVICAL FOLLOW-UP

14. **Further Follow-up Needed**
   - ☐ No
   - ☐ Yes Colposcopy/biopsy/ECC on ___/___/____ (MM DD YYYY) ☐ onsite
   - ☐ Refused
   - ☐ Lost to Follow-Up

15. **Treatment**
   - ☐ Treatment Started on ____/____/_____ (MM DD YYYY)
   - ☐ Refused
   - ☐ Lost to Follow-up
   - ☐ Pending _____/_____/______ (MM DD YYYY)

   Referred:__________________________ (Facility)

16. **Treatment Type**
   - ☐ Cryosurgery (not therapy)
   - ☐ Cold/Knife Cone/Conization
   - ☐ Hysterectomy
   - ☐ To Be Determined
   - ☐ Laser Treatment
   - ☐ LEEP/LETZ
   - ☐ Other _____________________

16a. **Treatment Report Attached** ☐ Yes

D. FINAL DIAGNOSIS

17. Date: ___/___/____

   Final Diagnosis Status
   - ☐ Work-up complete
   - ☐ Work-up pending
   - ☐ Lost to follow-up
   - ☐ Work-up refused
   - ☐ Irreconcilable

   Final Diagnosis Date of Final Diagnosis __/__/___
   - ☐ Normal/Benign reaction/inflammation
   - ☐ HPV/Condylomata/Atypia
   - ☐ CIN1/mild dysplasia (biopsy diagnosis)
   - ☐ CIN2/moderate dysplasia (biopsy diagnosis)
   - ☐ CIN3/severe dysplasia/Carcinoma in situ (stage 0) or Adenocarcinoma In Situ of the cervix (AIS)(biopsy diagnosis)
   - ☐ Low grade SIL (biopsy diagnosis)
   - ☐ High grade SIL (biopsy diagnosis)
   - ☐ Other

E. COUNSELING

18. Counseled Time: ☐ <25min ☐ ≥25min

   Counseled On:
   - ☐ Abnormal Diagnostic Tests - CIN2 or CIN3 result, cancer, HSIL PAP test result prior to diagnostic procedure
   - ☐ Treatment Options
   - ☐ Medicaid Application
   - ☐ Abnormal Pap Test

The Health Insurance Portability and Accountability Act (HIPAA) requires that clients be given a copy of a notice of privacy practices which documents their rights related to the release of protected health information. This act allows for the release of health information when it will be used for treatment, payment, and operations.

Form Completion Date: ____/____/_____ (MM DD YYYY)

Name & Title ___________________________

BEST CHANCE NETWORK CERVICAL FOLLOW-UP/BILLING FORM
INSTRUCTIONS ON COMPLETING 1014-ENG-DPH

1. Service Date: Enter month, day, and four-digit year.

2. Type of Visit:
   a. First BCN Visit: If the BCN patient is seen for the first time at you facility. Check this box.
   b. Follow-up Visit: If patient has been seen at your facility for a previous follow-up visit, check this box.
   c. Report Only: Use this box for reporting any results or information on a patient other than an office visit and for reporting Non-BCN Funded Services.

3. Provider Site Label: Place label on original and on copy.

4. Name: Enter last name and then first name.

5. Birthdate: Enter month, day, and four-digit year.

6. Last Four Digits of Social Security Number or Med-IT Number: Enter this number.

7. Pelvic Exam Results (if performed at this visit): Check the appropriate box.

8. Cotesting Results (if performed at this visit): #8 – 10: Check the appropriate boxes and supply dates and other information.

11. Fill in the appropriate date and mark the appropriate box.

12. Mark appropriate box.

13. Mark box if biopsy report is attached.

14. Mark the appropriate box and enter date.

15. Cervical Treatment: Mark the appropriate box, enter dates, and name of facility as needed.

16. Treatment Type: Mark the appropriate box and enter information as needed.

16a. Mark box if treatment report is attached.

17. Counseling: Mark the appropriate box. CPT code for counseling should be billed on CMS-1500.

Enter name, title and form completion date. The person completing this form 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.

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

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

Note: If you have any questions regarding completion of this form correctly, please call your BCN Regional Service Coordinator