SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Best Chance Network
Referral Form

Please fax referral and reports to 803-898-0163

1. **Authorization Code:** _____
2. **Appointment Date:** ____/____/_____
   MM DD YYYY

3. This is a referral for:

BCN Screening
☐

Breast Follow-up
☐ Mammogram (screening)
☐ Mammogram (diagnostic)
☐ Ultrasound (breast)
☐ MRI (breast)
☐ Radiological Breast Biopsy or FNA
☐ Surgical Consult & Breast Exam

Cervical Follow-up
☐ Pap Smear
☐ HPV Test
☐ Cervical Consult & Colposcopy
☐ Cervical biopsy
☐ ECC
☐ Endometrial biopsy
☐ Diagnostic LEEP or conization

Navigation
☐ Medicaid Application

4. Client Barriers
☐ Financial ☐ Language ☐ Transportation ☐ No Barriers Identified
☐ Knowledge ☐ Support ☐ Other

5. Client Referred: _____ **DOB:** _____/_____/ _____
Last Name First Name MM DD YYYY

Address: _____
PO Box/Street City State Zip Code

Phone #: (___)_____ Social Security # (Last four digits): _____ County: _____

6. Referred From: _____
Facility

Address: _____
PO Box/Street City State Zip Code

Phone #: (___)_____ Fax #: _____

7. Referred To: _____
Facility

Address: _____
PO Box/Street City State Zip Code

Phone #: (___)_____ Fax #: _____

8. Person Completing Referral: _____ **Date:** _____/ _____/ _____
Name/Title MM DD YYYY

9. Comments:

The Health Insurance Portability and Accountability Act (HIPAA) requires that clients be given a copy of a notice of privacy practices which documents clients' 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.

Best Chance Network
Referral Form
Instructions for Completing 4126-ENG-DPH

Purpose: This form is to be used by contracted BCN medical providers while rendering BCN services.

Please review BCN's current fee schedule to ensure that BCN services rendered are allowable for reimbursement.

Please complete this form when client is referred for Best Chance Network (BCN) breast and cervical screening and follow-up services. Send the original with the client or mail referral to the provider after you call to schedule the appointment. Maintain the yellow copy as a reminder to call for report.

You may refer your clients to BCN Patient Navigation if they need additional support.

Audience: BCN contracted medical providers.

Instructions:

1. **Authorization Code:** Enter the client's prior authorization (PA) code issued by DPH.
2. **Appointment Date:** Please enter the client's appointment date.
3. **Referred Services:** Complete by checking the appropriate box(es) for services the client is being referred for. Submit all client reports with referral form.
4. **Client Barriers:** Complete by checking the appropriate box(es) for client barriers that may require patient navigation.
5. **Client Referred:** Complete by identifying data for the BCN client being referred.
6. **Referred From:** Complete by identifying the referring facility (the office making the referral). Enter the fax and phone number where the facility can be reached.
7. **Referred To:** Complete by identifying the facility the client will be referred to (the office receiving the referral). Enter the fax and phone number where the facility can be reached.
8. **Person Completing Referral:** Complete by identifying the person who is making the referral and their appropriate title. Please include the date the referral form was completed.
9. **Comments:** Give additional information that might help in providing services for the client.

Office Mechanics and Filing: Retain this form in the record for six years after the contract expiration date. DPH BCN scans the original, uploads to the database, and shreds original per Agency protocol. BCN records shall be available for audit.

Please contact your Regional Provider Coordinator if you have any questions regarding completing this form or coverage of services.

Retention Schedule: This form is subject to Retention Schedule 9076.