West Virginia Department of Health and Human Resources

Office of Maternal, Child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Referral Form

All results plus the Radiology or Cervical Diagnostic Reports must be mailed to the screening provider and a copy must be forwarded with the invoice to the WVBCCSP. See bottom of form for the WVBCCSP address.

Screening Facility: _____ **BCC#:** _____

Screening Clinician: _____ **Date referred:** _____/_____/_____

Telephone: (_____) _____

Client Name (Last, First, MI): _____ **DOB:** _____/_____/_____

Social Security #: _____- ____- _____

Referral Provider

Referral Provider: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____**Phone: (____)** _____

Date Appointment: _____/_____ /_____ **Time:** _____

Breast Referral for:

- ☐ **Screening mammogram**
- ☐ **Screening mammogram unilateral**
- ☐ **Diagnostic mammogram bilateral**
- ☐ **Diagnostic mammogram unilateral**
- ☐ **Breast biopsy**
- ☐ **Fine needle aspiration**
- ☐ **Puncture aspiration of cyst**
- ☐ **Surgical consultation**
- ☐ **Ultrasound:** ***reimbursed when performed within one month of Mam***

Date of Mammogram: _____ /_____ /_____

Reimbursement rendered for approved CPT codes ONLY.

CBE result	Most Recent Pap Test	Indication for Colposcopy

Date Performed: ____/____ /_____

- ☐ Bloody/Serous Nipple Discharge
- ☐ Discrete Palp mass
- ☐ Skin dimpling/retraction
- ☐ Nipple/Areolar Scaliness
- ☐ Normal Exam
- ☐ Not done – normal CBE for past 12 months
- ☐ Not done – other/unknown reason
- ☐ Refused

Paid for by WVBCCSP ☐ **Yes** ☐ **NO**

Date Performed: _____ /_____ /_____

Paid for by WVBCCSP? ☐ **Yes** ☐ **No**

Reminder: ***a copy of the test report must be attached to this form.***

Pap test result of:

- ☐ Visualized cervical lesion
- ☐ Adenocarcinoma
- ☐ AIS
- ☐ AGC
- ☐ ASC-H
- ☐ *ASC-US (with a +, high-risk HPV test)*
- ☐ HSIL
- ☐ LSIL
- ☐ Squamous cell carcinoma.

Facility performing test: _____

I understand that I have met the eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). I may have health insurance and still be eligible for this referral to be paid for fully or partially by the WVBCCSP. My insurance will be billed first. I also understand that the program will not cover pre-operative testing and certain other procedures that may be ordered. I will take this referral form to the physician or facility named above when I go to my appointment.

Patient Signature: _____ **Date:** _____/_____/_____

Original: Physician Copy: WVBCCSP Copy: Screening Provider Copy: Patient WVBCCSP Form # Y202 Rev. 06/2022

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston WV 25301 Tel: (304) 558-5388 or 1-800-642-8522