

Breast Diagnostic Enrollment, Follow Up & Treatment Plan for Women 18-74

Version: September 2014



301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

PROVIDER NOTES:

- If client currently enrolled for screening services complete ONLY the name and date of birth on pages 3 and 4.
- Male clients - NOT eligible for screening or diagnostic procedures.

Reasonable accommodations made for persons with disabilities. TDD (800)833-7352. Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

INSTRUCTIONS: Please answer each question and PRINT clearly!

DEMOGRAPHICS

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ Marital Status: Single Married Divorced

Birthdate: month / day / year Gender: Female Male Social Security #: _____ - _____ - _____

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Preferred way of Contact?: Home Work Cell
Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Yes I want to receive program information by email. Email: _____

In case we can't reach you: _____ Relationship: Spouse Family/Friend
Contact person: _____ Other _____

Phone: (_____) _____ Home Work Cell

Address: _____ City: _____ State: _____ Zip: _____

Are you of **Hispanic/Latina(o)** origin? Yes No Unknown Country of origin: _____

What is your **primary language** spoken in your home? English Spanish Vietnamese Other _____

What **race or ethnicity** are you? *(check all boxes that apply)*

American Indian/Alaska Native Tribe _____
 Black/African American
 Mexican American
 White
 Asian
 Pacific Islander/Native Hawaiian
 Other _____
 Unknown

Are you a **Refugee**? Yes No DK* If yes, where from: _____

Highest level of **education** completed: 1 2 3 4 5 6 7 8 9 10 11 12
 13 14 15 16 16+ GED Don't Know Don't Want to Answer

How did you **hear about the program**: Doctor/Clinic Family/Friend Agency
 Newspaper/Radio/TV I am a Current/Previous Client Community Health Worker
 Other _____

INCOME & INSURANCE

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your **household income before taxes**? Weekly Monthly Yearly Income: \$ _____

Please Note: Self employed are to use net income after taxes.

How many **people** live on this income? 1 2 3 4 5 6 7 8 9 10 11 12

Do you have **insurance**? Yes None/No Coverage If **yes**, is it: Medicare (for people 65 and over)
 Part A and B Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement
(please list) _____

BREAST & CERVICAL

1. Have **you** ever had any of the **following tests**?
Pap test Yes No DK* Most Recent Date ___/___/___ The result: Normal Abnormal DK*

Mammogram (breast x-ray) Yes No DK* Most Recent Date ___/___/___ The result: Normal Abnormal DK*

2. Have **you** ever had a **hysterectomy** (removal of the uterus)? No Yes DK*

2a. Was your **hysterectomy** to treat cervical cancer? No Yes DK*

3. Has your **mother, sister or daughter** ever had **breast cancer**? No Yes DK*

4. Have **you** ever had **breast cancer**? No Yes DK* When: ___/___/___

5. Have **you** ever had **cervical cancer**? No Yes DK* When: ___/___/___

*DK - Don't Know/Not Sure

Continue to Page 2 → → →

Informed Consent and Release of Medical Information

■ You must **read and sign this page** to be a part of the Every Woman Matters Program.

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- I want to be a part of the Every Woman Matters (EWM) Program. I know:
 - I can only receive breast diagnostic tests if I am under the age of 40
 - I cannot be over income guidelines
 - If I have insurance, EWM will only pay after my insurance pays
 - I must be a female (per Federal Guidelines)
 - I will notify EWM if I do not wish to be a part of this program anymore
- I know that if I am under 40 years of age, I will not be a part of EWM after I have had my breast cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.
- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and/or cervical cancer screening, follow up exams, diagnostic tests and/or treatment to EWM.
- To assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health care providers.
- My name, address, email, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

◆ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front and back copy of my USCIS documentation. (example: permanent resident card)

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Your Name (first, middle, last)

Your Signature

month / day / year

month / day / year

Date of Your Signature

Your Date of Birth

Completion of this form is required. Breast Follow Up & Treatment Plan

First Name	MI	Last Name	Date of Birth month / day / year
Provider Information			
Screening Provider	Name	Address	
Diagnostic Provider	Name	Address	Date of Referral month / day / year
Date of Clinical Breast Exam ____/____/____		Date of Screening Mammography ____/____/____	

Age	CBE Findings:	Services Allowable for Reimbursement Based On Findings:	
18-29	<input type="checkbox"/> Suspicious CBE <small>(Consultation by surgeon preferred)</small>	<input type="checkbox"/> Surgical Consultation* <input type="checkbox"/> Breast Ultrasound	Date of Service: ____/____/____ Date of Service: ____/____/____
	30-39	<input type="checkbox"/> Suspicious CBE or <input type="checkbox"/> Diagnostic mammography findings <small>(Consultation by surgeon preferred)</small>	<input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Breast Biopsy type _____ <input type="checkbox"/> Breast MRI** **NEEDS PRE-AUTHORIZATION. See page 4 for eligibility

Screening mammogram not covered by EWM for women <40

Age	Mammography Findings:	Services Allowable for Reimbursement Based On Findings:		
40-74	<input type="checkbox"/> No Mammography	<input type="checkbox"/> Suspicious CBE	<input type="checkbox"/> Consultation* <input type="checkbox"/> Repeat Breast Exam <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Breast Biopsy type _____ <input type="checkbox"/> Diagnostic Mammogram <i>alone does not meet standard of care</i> <input type="checkbox"/> Breast MRI** **NEEDS PRE-AUTHORIZATION. See page 4 for eligibility	Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____
	<input type="checkbox"/> BI-RADS 0 Needs additional imaging evaluation		<input type="checkbox"/> Comparison of prior films <input type="checkbox"/> Diagnostic mammogram (CAD is not covered) <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Breast Biopsy type _____	Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____
	<input type="checkbox"/> BI-RADS 1 - Negative or <input type="checkbox"/> BI-RADS 2 - Benign finding	CBE negative or CBE suspicious for malignancy	Routine Screening <input type="checkbox"/> Consultation* <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Breast Biopsy type _____ <input type="checkbox"/> Breast MRI** **NEEDS PRE-AUTHORIZATION. See page 4 for eligibility	Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____ Date of Service: ____/____/____
	<input type="checkbox"/> BI-RADS 3 - Probably Benign		Diagnostic mammogram/breast ultrasound at 6 months	
	<input type="checkbox"/> BI-RADS 4 - Suspicious Abnormality or <input type="checkbox"/> BI-RADS 5 - Highly suggestive of malignancy		<input type="checkbox"/> Consultation* Consulting physician: _____ <input type="checkbox"/> Breast Biopsy type _____	Date of Service: ____/____/____ Date of Service: ____/____/____
	<input type="checkbox"/> Client refused diagnostic workup Procedure Refused _____		Date of refusal ____/____/____	Did client make Informed Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason Refused _____
<input type="checkbox"/> Consultation*		<input type="checkbox"/> 2nd Opinion	Date of Service: ____/____/____	

*Consultations can only be reimbursed if provider normally brings client into the office for consultation.

REQUIRED!	Mark Final Diagnosis Date or Pathology Report Date: ____/____/____	
	Check One: <input type="checkbox"/> Cancer not diagnosed, treatment not indicated <input type="checkbox"/> Inconclusive	<input type="checkbox"/> Cancer Diagnosed <input type="checkbox"/> Ductal carcinoma <input type="checkbox"/> Lobular carcinoma in situ <input type="checkbox"/> Invasive Cancer <small>Please give name and address of treatment provider on page 4</small>

Clinic Name and Address:	Date form Completed: ____/____/____
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Breast Follow Up & Treatment Plan

First Name	MI	Last Name	Date of Birth month / day / year
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Preauthorization for MRI

EWM reimburses for the Screening MRI as an adjunct to screening mammogram and CBE for the following clients any age with high risk of breast cancer. Please check one or more that apply to the client.

- Lifetime risk 20-25% based on family history, using breast cancer tool: www.cancer.gov/bcrisktool/
- Known BRCA1 or BRCA2 Date of Genetic Testing ___/___/___
- First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child) Relative _____ Date of Genetic Testing ___/___/___
- Previous Radiation Therapy (to chest, between the ages of 10-30) Age: _____ Purpose of Radiation: _____

Provider Note: Provide copy of appropriate document

Facility _____	Clinician _____
Attention _____	Provider Phone Number (____) _____
	Provider Fax Number (____) _____

Program Staff Use ONLY:	Enrollment Date: ___/___/___	EWM Fax: 402-471-0913
	Request Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Funding Available <input type="checkbox"/> Yes <input type="checkbox"/> No
	Program Signature _____	Expiration Date: ___/___/___
	Date of Signature ___/___/___	<i>*Approval is good for one month after Date of Signature</i>

Breast Cancer Treatment

- Client referred to another provider who will take over care

Referral Clinician Information - *clinician name, clinic name, city name (do not abbreviate clinic name)*

**Consultations can only be reimbursed if provider normally brings clients into the office for consultation.*

- Consultation* Date ___/___/___ *To give client treatment options*

Treatment Regimen consist of _____ *(lumpectomy, mastectomy, radiation, chemotherapy, etc)*
 Date Treatment started/initiated ___/___/___ *(date of surgery, chemotherapy, radiation, etc.)*

Complete Treatment Funds Request form if client needs financial assistance

- Client refused diagnostic workup Date of refusal ___/___/___ Did client make Informed Decision? Yes No
- Procedure Refused _____ Reason Refused _____

Breast Cancer Treatment - to be completed by the provider who initiated

Date _____

Name and Address of Clinic initiating/completing *(do not abbreviate clinic name)*

Surveillance / Follow Up

History of Prior Breast Screening, Diagnostic Tests and Treatment

Last Clinical Breast Exam Result/Finding _____	Date ___/___/___
Last Screening or Diagnostic Mammogram Result/Finding _____	Date ___/___/___
Last Breast Ultrasound Result/Finding _____	Date ___/___/___
Last Treatment _____	Date ___/___/___

6 Month Follow Up (only for clients 40-74)

- Client reports symptoms
- Clinical Breast Exam *(Clinical Breast Exam strongly recommended and reimburseable by EWM)* Date ___/___/___
 - Negative/Benign
- Mammogram Date ___/___/___
 - Negative/Benign
 - Probably Benign
- Breast Ultrasound Date ___/___/___
 - Negative/Benign

NOTE: If client has findings other than negative or benign refer to Page 3 of this form for further required follow up

Surveillance/Follow Up - to be completed by the provider who initiated

Date _____

Name and Address of Clinic initiating/completing *(do not abbreviate clinic name)*

Breast Diagnostic Enrollment/Follow-up & Treatment Plan Instructions

EWM Medical Advisory Board Recommends that EWM follow the 2013 NCCN Guidelines approved by the Center for Disease Control and Detection (CDC). NCCN Guidelines can be found at: www.nccn.org.

Enrollment must be used for:

Women 40+ who have had abnormal screening – if they are currently enrolled and have an abnormal screening, the provider only needs to complete page 3 of the form.

Women under 40 who have had with in the last 6 months a:

- a. CBE suspicious for malignancy
- b. Diagnostic mammogram, for women 30-39, with findings of:
 - Suspicious Abnormality (SAB)
 - Highly suggestive (MAL)
 - Assessment incomplete (NAE)

Providers review page 1 and 2 for completion by client (if not completed client is considered not enrolled):

Page 1 of the form must be completed with:

- Demographic information
- Income & insurance
- Breast & Cervical History

Page 2 must be completed with:

- Citizenship Status
- Alien Status (*client must provide a copy of their **Permanent Resident Card***)
- Signature may not be after the date of service in order for services to be reimbursed

All clients must have:

- Current signature on file with EWM for 'Informed Consent and Release of Medical Information'.
- Any new client enrolling for diagnostic services must complete all information on pages 1 and 2 including a current signature and date of signature.
- Any client previously enrolled for screening services more than 12 months must also complete pages 1 and 2.

Providers must complete the following: (DO NOT SUBMIT the form UNLESS ALL OF THESE ITEMS ARE COMPLETE)

1. Make sure the client has completed page 1 and 2 with a signature/date of signature
2. Check the box with the abnormal findings
3. Check the box indicating corresponding diagnostic procedure done and date
4. Check the final diagnosis and date of diagnosis
5. Attach all documents if appropriate (copies of breast ultrasound, diagnostic mammogram, pathology reports on biopsies)
6. Indicate type of treatment if client has cancer diagnosis
7. Fill in the clinic name

6 Month Surveillance and Follow Up (Women 40-74):

1. 6 month follow up for clients with a probably benign result can be found on Page 4.
2. Client Must be enrolled
3. CBE expected before the follow up imaging performed
4. Preauthorization NOT needed

CRITICAL REMINDERS:

- Breast Ultrasound (ages 18-39) does NOT need preauthorization if ordered by a surgeon or radiologist following a diagnostic mammogram (in clients 30-39). Primary providers may order a breast ultrasound if in rural areas as there may not be a surgeon available, verbal pre-approval required please call EWM (phone number on the first page).
- Breast MRI requires pre-approval
- NO old diagnostic forms will be accepted
- Diagnostic procedures must correspond with screening results
- Consultation can only be reimbursed if provider normally brings clients in the office for consultation
- Computer aided detection (CAD) is not covered
- Diagnostic office visit in accordance with the Program Guidelines (see page 25 of the 2014 Women's & Men's Health Provider Contract Manual found at: http://dhhs.ne.gov/publichealth/Documents/EWM_Manual.pdf).