

# Breast Diagnostic Enrollment, Follow Up & Treatment Plan for Women 18-74 (BDIA Form)

Every Woman Matters



Version: June 2016



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:

- Please have client complete pages 1-2. If not completed, the client CANNOT be enrolled.
- 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.

Please answer each question and PRINT clearly!

CONTACT INFORMATION

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Maiden Name:** \_\_\_\_\_ **Marital Status:**  Single  Married  Divorced

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security #:** \_\_\_\_-\_\_\_\_-\_\_\_\_ **Birth place** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City and state or country of birth** \_\_\_\_\_  
**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: \_\_\_\_\_

EMERGENCY CONTACT

**Contact person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_  Home  Work  Cell

DEMOGRAPHICS

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

**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  
 Agency  
 Newspaper/Radio/TV  
 Family/Friend  
 I am a Current/Previous Client  
 Community Health Worker  
 Other \_\_\_\_\_

HEALTH HISTORY

**Have you ever had any of the following tests?:**

**Pap test**  Yes  No  DK\*  
Most Recent Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
The result:  Normal  Abnormal  DK\*

Have **you** ever had a **hysterectomy** (removal of the uterus)?  Yes  No  DK\*  
2a. Was your cervix removed?  Yes  No  DK\*  
2b. Was your **hysterectomy** to treat cervical cancer?  Yes  No  DK\*

Have **you** ever had cervical cancer?  
 No  Yes  DK\* When: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mammogram**  Yes  No  DK\*  
Most Recent Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
The result:  Normal  Abnormal  DK\*

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

Have **you** ever had breast cancer?  
 No  Yes  DK\* When: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*DK - Don't Know/Not Sure

Finish the section below... read the consent... check a box... then sign & date and you're done!

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 only  
 Part A and B  
 Medicaid (full coverage for self)  
 Private Insurance with or without Medicaid Supplement (please list)  
\_\_\_\_\_

## 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:
  - If I am under the age of 40, I can *only* receive breast diagnostic tests.
  - 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.

CHECK ONE

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.

SIGN AND DATE

Please Print Your Name (first, middle, last)

Your Signature

month / day / year

Date

month / day / year

Your Date of Birth

# Breast Follow-Up & Treatment Plan

<b>Name:</b>	First	Last	DOB
<b>Provider information:</b>	<b>Screening:</b> Clinic that initiated care	City/Phone Number	
	<b>Diagnostic:</b> Clinic that patient was referred to	City/Phone Number	

**--Instructions: Please send EWM this form along with corresponding radiology and/or pathology reports when diagnostic workup is complete.--**

<h2 style="text-align: center; background-color: #fce4ec;">Ages 18-39</h2> <p><b>Screening history:</b>  <b>Clinical Breast Exam</b> Date: __/__/__  <input type="checkbox"/> Normal/Benign <input type="checkbox"/> Suspicious for breast malignancy</p> <p><b>Diagnostic workup:</b>          Date: __/__/__</p> <p><input type="checkbox"/> Surgical Consultation          Physician: _____          • If CBE is suspicious, EWM encourages surgical consult before radiology services</p> <p><input type="checkbox"/> Breast Ultrasound          Date: __/__/__          • Preferred: Referral to surgeon for evaluation and to determine need for u/s          • Acceptable: Breast u/s ordered by Primary Care Provider if no surgeon available</p> <p><input type="checkbox"/> Diagnostic mammogram          Date: __/__/__          • Client must be at least age 30 to have a Diagnostic Mammogram          • Computer Aided Detection (CAD) is not covered          • Diagnostic mammogram <b>alone</b> does not meet standard of care if CBE is suspicious</p> <p><input type="checkbox"/> Repeat Breast Exam          Date: __/__/__</p> <p><input type="checkbox"/> Breast Biopsy type: _____          Date: __/__/__</p> <p><input type="checkbox"/> Breast MRI requires pre-approval See page 4          Date: __/__/__</p> <p><input type="checkbox"/> Consultation/2<sup>nd</sup> opinion          Date: __/__/__</p> <p><input type="checkbox"/> Cytology of breast discharge          Date: __/__/__</p> <p><input type="checkbox"/> Client refused Initiate: Client Informed Refusal Form/Service Provider Document</p>	<h2 style="text-align: center; background-color: #fce4ec;">Ages 40-74</h2> <p><b>Screening history:</b>  <b>Clinical Breast Exam</b> Date: __/__/__  <input type="checkbox"/> Normal/Benign <input type="checkbox"/> Suspicious for breast malignancy</p> <p><b>Results of initial SCREENING mammogram, if applicable</b> Date: __/__/__</p> <p><input type="checkbox"/> BI-RADS 0 – Assessment incomplete  <input type="checkbox"/> BI-RADS 1 – Negative <input type="checkbox"/> BI-RADS 2-Benign finding <input type="checkbox"/> Screening Mammogram was NOT PERFORMED  <input type="checkbox"/> BI-RADS 3 – Probably benign  <input type="checkbox"/> BI-RADS 4 - Suspicious abnormality <input type="checkbox"/> BI-RADS 5 – Highly suspicious</p> <p><b>Diagnostic workup:</b>          Date: __/__/__</p> <p><input type="checkbox"/> Surgical Consultation          Physician: _____          Date: __/__/__</p> <p><input type="checkbox"/> Breast Ultrasound          Date: __/__/__</p> <p><input type="checkbox"/> Diagnostic mammogram          Date: __/__/__          • Computer Aided Detection (CAD) is not covered          • Diagnostic mammogram <b>alone</b> does not meet standard of care if CBE is suspicious</p> <p><input type="checkbox"/> Repeat Breast Exam          Date: __/__/__</p> <p><input type="checkbox"/> Breast Biopsy type: _____          Date: __/__/__</p> <p><input type="checkbox"/> Breast MRI requires pre-approval See page 4          Date: __/__/__</p> <p><input type="checkbox"/> Consultation/2<sup>nd</sup> opinion          Date: __/__/__</p> <p><input type="checkbox"/> Cytology of breast discharge          Date: __/__/__</p> <p><input type="checkbox"/> Client refused Initiate: Client Informed Refusal Form/Service Provider Document</p>
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**See table of reimbursable procedures on page 6 to verify coverage**

<p><b>★ Final Diagnosis:</b> This section must be completed before sending in.</p>	<p><b>Date of final diagnosis or pathology report:</b>          __/__/__</p> <p><b>Clinic name:</b> _____</p>	<p><b>Check one:</b>  <input type="checkbox"/> Cancer <b>not</b> diagnosed – no treatment necessary  <input type="checkbox"/> Cancer diagnosed – Please fill out Breast Cancer Treatment section on page 4  <input type="checkbox"/> Ductal carcinoma in situ <input type="checkbox"/> Lobular carcinoma in situ  <input type="checkbox"/> Other carcinoma in situ <input type="checkbox"/> Invasive cancer</p> <p><b>Date:</b> _____</p>
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• Fax to 402-471-0913 or mail to Every Woman Matters, PO Box 94817 Lincoln, NE 68509-4817  
• Call us with any questions at 1-800-532-2227. ★ Print out forms online at [www.dhhs.ne.gov/ewmforms](http://www.dhhs.ne.gov/ewmforms)

# Breast Follow-Up & Treatment Plan

<b>Client information:</b>	First Name _____	MI _____	Last Name _____	DOB _____
<b>Breast Cancer Referral &amp; Treatment</b> (see page 5 bottom right)				
<b>Referral:</b>	Client referred to _____ who will take over care. <small>Clinician and clinic name and city and phone</small>			
<b>Consultation:</b>	Consultation Date to give client options _____			
<b>Treatment:</b>	Treatment regimen consists of _____ (lumpectomy, surgery, chemo, radiation, etc) Treatment date _____			
<b>Refusal:</b>	Cancer treatment refused date _____ Client made informed decision yes/no Reason for refusal: _____			

## Screening MRI Preauthorization Request

**EWM reimburses for screening MRI as an adjunct to screening mammogram and CBE for the clients that meet the following criteria, starting at age 25:**  
 Check one or more that apply to the client, and provide appropriate clinical documentation. Fax to 402-471-0913

Lifetime risk of 20-25% or greater based on family history using the breast cancer tool for women 35+: [www.cancer.gov/bcrisktool/](http://www.cancer.gov/bcrisktool/)

For women under 35, go to [www.crahealth.com/risk-express](http://www.crahealth.com/risk-express) or call us to run risk report.

Known BRCA1 or BRCA2 mutation  
Date of genetic testing: \_\_\_/\_\_\_/\_\_\_ Relative: \_\_\_\_\_

First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child)  
Date of genetic testing: \_\_\_/\_\_\_/\_\_\_ Relative: \_\_\_\_\_

Previous Radiation Therapy to chest, between the ages of 10-30 Age: \_\_\_\_\_ Purpose of radiation: \_\_\_\_\_

**Requesting provider information:**  
 Clinic name \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

**EWM staff use only.** Request approved:  Yes  No Program signature: \_\_\_\_\_ Date \_\_\_\_\_ Authorization expires one month after date of signature

## Follow-up of Previous Abnormal Finding

**Past results: why does client need follow-up?** →

**Last Clinical Breast Exam Result/Finding:**  Negative/Benign  Suspicious for breast malignancy Date \_\_\_\_\_

**Last Screening or Diagnostic Mammogram Result:** \_\_\_\_\_ Date \_\_\_\_\_

**Last Breast Ultrasound Result:** \_\_\_\_\_ Date \_\_\_\_\_

**Last Treatment** \_\_\_\_\_ Date \_\_\_\_\_

**6 Month Follow Up: Only for clients 40-74.** What are the client's **current** results? Please note follow-up is not reimbursable for clients under 40.

- **Client reports symptoms:**  NO  YES, list symptoms \_\_\_\_\_
- **DATE:** \_\_\_/\_\_\_/\_\_\_ **Clinical Breast Exam Results (check one):**  Negative/Benign  Suspicious for breast malignancy
- **DATE:** \_\_\_/\_\_\_/\_\_\_ **Mammogram Results (check one):**  Assessment Incomplete  Negative  Benign  Probably Benign  Suspicious Abnormality\*  Highly Suspicious for Malignancy\*
- **DATE:** \_\_\_/\_\_\_/\_\_\_ **Breast Ultrasound Results (check one):**  Assessment Incomplete  Negative  Benign  Probably Benign  Suspicious Abnormality\*  Highly Suspicious for Malignancy\*
- **DATE:** \_\_\_/\_\_\_/\_\_\_ **Consultation by** \_\_\_\_\_ Clinic Name \_\_\_\_\_
- **DATE:** \_\_\_/\_\_\_/\_\_\_ **Biopsy:** Type \_\_\_\_\_ Results: \_\_\_\_\_

**Name of Clinic:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Must do new workup on page 3

# Instructions

**About this form:** This form is to be used **ONLY** for women with an **abnormal breast exam** or **abnormal screening mammogram** that are in need of further testing to diagnose whether or not breast cancer is present.

Your client does not have to be currently enrolled in our program to use this form. **This form can be used to enroll clients ages 18-74 in Every Woman Matters to cover diagnostic testing** as long as they 1) meet our income guidelines and 2) are US citizens or have a Permanent Residency card. Call us at 1-800-532-2227 or check our website for current income guidelines. <http://dhhs.ne.gov/PublicHealth/EWM/Pages/Home.aspx>

## What providers need to do:

### Review pages 1 and 2 for completion by client

• **If not completed, the client cannot be enrolled.** If the client is currently enrolled and recently filled out a Healthy Lifestyle Questionnaire, pages 1 and 2 don't need to be completed or returned. Call if you are not sure.

### Page 1 must be completed with:

- Contact information
- Demographics
- Breast and cervical history

### Page 2 must be completed with:

- Income and insurance
- Citizen Status or Alien Status (client must provide a copy of their Permanent Resident Card)
- Signature (date of signature must be date of first service for it to be reimbursed)

### Complete page 3

This can be filled out by any member of the health care team

- **Do NOT SUBMIT unless ALL OF THESE ITEMS ARE COMPLETE:**
- Check the box with the abnormal findings and the box indicating corresponding diagnostic procedure done and date
- Check the **final diagnosis and date of diagnosis**
- Fill in the clinic name

### Attach documentation

- **Please remember to attach all clinical documentation** if appropriate (copies of breast ultrasound, diagnostic mammogram, pathology reports on biopsies). Form may be returned to you if documentation isn't included.

**Guidelines for Reimbursement:** The Every Woman Matters Medical Advisory Board Recommends that we follow the 2015 NCCN Guidelines approved by the Centers for Disease Control and Prevention (CDC). NCCN guidelines can be found at [www.nccn.org](http://www.nccn.org). Refer to reverse side for a table of reimbursable procedures.

## CRITICAL REMINDERS:

- Providers must follow 2015 NCCN guidelines --**Breast MRI requires pre-approval (see page 6 middle row)**--
- We only accept diagnostic forms printed July 2014 or later (see top right corner of front sheet)
- 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

### Clients who need surveillance/follow-up from a previous abnormal ultrasound or mammogram:

- Follow-up is reimbursable only for clients ages 40-74
- Client must be enrolled. Call if you are not sure.
- Pre-authorization not needed, but must follow NCCN guidelines.
- CBE expected before the follow-up imaging performed
- Complete "Follow-Up of Previous Abnormal Finding" section, page 4

### If client gets diagnosed with breast cancer:

- Indicate type of treatment and where client is being referred to by completing page 4 – Breast Cancer Referral & Treatment.
- Fill out Treatment Funds Request Form to access treatment funds
- Client may be eligible for Nebraska Medicaid for cancer treatment. Call us for more information.

# EWM Coverage of Diagnostic Services

Coverage is determined by the age of the client and the results of screening, following guidelines from NCCN.

## Procedures covered for women 18-39:

- Screening mammogram not covered by EWM for women <40

Age	CBE Findings:	Services Allowable for Reimbursement Based On Findings:
<b>18-29</b>	Suspicious CBE (Consultation by surgeon preferred)	Surgical Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) Breast Ultrasound Fine Needle Aspiration Breast Biopsy Cytology of breast discharge Breast MRI: NEEDS PRE-AUTHORIZATION. See page 4 for eligibility
<b>30-39</b>	Suspicious CBE (Consultation by surgeon preferred)	Same as list above, can also get diagnostic mammogram

## Procedures Covered for women ages 40-74:

- If the client did NOT have a screening mammogram, just had a breast lump or other cause for concern, see the first row.
- If she had a screening mammogram, see the column to the right of the results of the screening mammogram to determine if services are covered.

Age	SCREENING Mammogram Findings:	Services Allowable for Reimbursement Based On Screening Results:		
<b>40-74</b>	<b>No <u>Screening</u> Mammogram and Suspicious CBE (palpable mass, etc)</b>  See Diagnostic mammogram findings ->	<u>Diagnostic</u> mammogram <b>BI-RADS 0-3</b>	Breast Ultrasound is required (diagnostic mammography alone misses 15-20% of tumors)	
		<u>Diagnostic</u> mammogram <b>BI-RADS 4, 5</b>	Fine Needle Aspiration Breast Biopsy Breast MRI: NEEDS PRE-AUTHORIZATION. See page 4 for eligibility	
	<b>BI-RADS 0</b> - Needs additional imaging evaluation	Comparison of prior films Diagnostic mammogram (CAD is not covered) Breast Ultrasound Breast Biopsy		
	<b>BI-RADS 1</b> - Negative or <b>BI-RADS 2</b> - Benign finding	<b>CBE negative</b>	Routine Screening	
		<b>CBE suspicious for malignancy</b>	Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) Breast Ultrasound Fine Needle Aspiration Breast Biopsy Cytology of breast discharge Breast MRI: NEEDS PRE-AUTHORIZATION. See page 4 for eligibility	
	<b>BI-RADS 3</b> – Probably Benign	Diagnostic mammogram at 6 months, then every 6-12 months for 2-3 years		
<b>BI-RADS 4</b> – Suspicious Abnormality or <b>BI-RADS 5</b> – Highly suggestive of malignancy	Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) Breast Biopsy			