

Every Woman Matters Mammography Order



Clinic: This form must be completed prior to receiving services

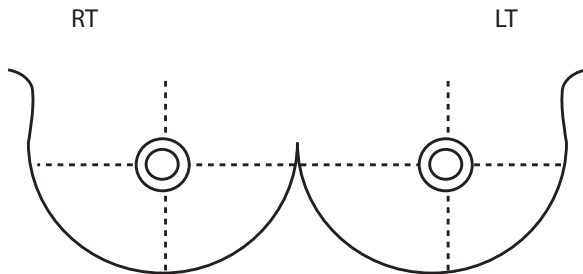
Facility: Send a copy of the dictated report to the ordering provider and EWM

First Name	Initial	Last Name	Date of Birth	Age
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Clinic Site: _____ City: _____
(Please do not abbreviate)

This is an order for the above patient to receive the following:

- Screening Mammogram *(only covered for women 40 and over)*
- Diagnostic Mammogram *(only covered for women 30 and over)*
 Reimbursement for a diagnostic mammogram for clients 30-39 only with suspicious CBE or previous abnormal mammogram
- Breast Ultrasound
(No pre-approval necessary if ordered by a surgeon or radiologist following a diagnostic mammogram in clients 30-39. Please call 1-800-532-2227 if rural area and no surgeon available.)
- CHECK HERE IF ADDITIONAL STUDIES MAY BE PERFORMED AS DETERMINED BY THE RADIOLOGIST
(Per program policies as stated in Women's and Men's Health Program 2017 Provider Contract Manual)



Provider Remarks:

Provider's Signature: _____ Date: _____

Provider signature may serve as an order if facility allows.

Women's and Men's Health Programs - Every Woman Matters Program - 301 Centennial Mall South - P.O. Box 94817 - Lincoln, NE 68509-4817
 Toll-Free: 800.532.2227 - In Lincoln: 402.471.0929 - Fax: 402.471.0913 - Web: www.dhhs.ne.gov/EWM
 #1NU58DP006278-01-00 #6NU58DP004863-04-02

Part 1

Billing/Admissions/Patient Registration for Participating EWM Clients

1. This form is only used for EWM clients and should only be accepted by contracted EWM facilities.
2. Part 1 stays with the client to present to the Radiology Department. The Radiology Department can use Part 1 for tracking purposes.
3. Part 2 can be torn off and used for Billing/Admissions/Patient Registration purposes.

Client Name: _____

Date of Birth: ____/____/____

Part 2