

IMAGING BREAST EVALUATION REPORTING FORM

Please Print Clearly

	BCCHP#	Authorization #
CLIENT NAME (Last, First, MI)	DATE OF BIRTH	LAST FOUR SS# (optional)
IMAGING FACILITY/SITE	PREVIOUS IMAGING FACILITY/DATE (COMPARISON)*	CHART NUMBER
R E F E R R A L S O U R C E	REFERRING CLINIC SITE	REFERRING PROVIDER NAME
PRIMARY INSURANCE (IF THERE IS A PRIMARY INSURANCE COVERAGE, PLEASE SUBMIT EOB TO BCCHP FOR ADDITIONAL REIMBURSEMENT UP TO PROGRAM FEE SCHEDULE AMOUNT)		Policy/Identification number
Name of insurance company		
Type of test ordered: Screening: <input type="checkbox"/> Mammography <input type="checkbox"/> MRI* *Approval for high-risk screening MRI requires prior authorization and lifetime risk calculation. If available, please complete below: Was the Tyrer-Cuzick (IBIS) model used? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, Lifetime Risk: _____% (20% or higher is considered high risk) • Family history of breast cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Relative type: Age at dx: <input type="checkbox"/> • Positive for BRCA mutation, or first-degree relative <input type="checkbox"/> Yes <input type="checkbox"/> No Diagnostic: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Mammography <input type="checkbox"/> Ultrasound Personal history of breast cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No, Age at dx: Breast Implants <input type="checkbox"/> Yes <input type="checkbox"/> No Ordering Clinician's Remarks:		
Right  Left <i>A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE. Palpable breast masses need to be evaluated clinically and/or with ultrasound regardless of mammogram result.</i>		

FOR IMAGING FACILITY USE ONLY BELOW THIS LINE										
Type of Test			<input type="checkbox"/> Mammography <input type="checkbox"/> Digital <input type="checkbox"/> Conventional				<input type="checkbox"/> US		<input type="checkbox"/> MRI	
Mam		US								
L		R								
BI-RADS Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) Negative – The breast(s) are symmetric with no masses, architectural distortion or suspicious calcifications present.					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2) Benign – There is nothing to suggest cancer; benign findings that warrant reporting. No evidence of malignancy.					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(3) Probably Benign – Short Interval Follow-up recommended					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4) Suspicious Abnormality – Lesions do not have specific characteristics of breast cancer but have a possibility of being malignant. The radiologist has sufficient suspicion to warrant biopsy.					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5) Highly Suggestive of Malignancy – These lesions have a high probability of malignancy.					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(0) Assessment is Incomplete – Need additional evaluation. (Assessment Incomplete for a mammogram applies only if additional radiological studies are needed)					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Technically Unsatisfactory – Could not be interpreted (needs to be repeated)					
	Recom- mendations	<input type="checkbox"/> Additional Mammographic Views <input type="checkbox"/> Ultrasound <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Biopsy			<input type="checkbox"/> Surgical Consult / Repeat Breast Exam <input type="checkbox"/> Short Interval Follow-up Suggested in _____ months <input type="checkbox"/> Routine Screening Mammogram <input type="checkbox"/> Obtain Prior Films for Comparison*					
COMMENTS:										
DIAGNOSTIC PROVIDER SIGNATURE				Print Name			Telephone Number		Date	

Please FAX form to the BCCHP Prime Contractor at: