Breast and Cervical Cancer Early Detection Program (BCCP)
BCCP Screening/Referral Form

[FORM VALID FOR SCREENING AND REFERRALS/ORDERS FOR 12 MONTHS FROM DATE ENROLLED AND EXTENDS THROUGH THE END OF MONTH IT EXPIRES. FOR POSSIBLE SHORT-TERM EXTENSION, CONTACT THE BCC PROGRAM.]

SCREENING CLINIC: _____
ADDRESS: _____
CITY: _____
PHONE: ( )

CLIENT NAME: _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

BCCP ENROLLMENT DATE: ___/___/___ **DATE ENROLLMENT EXPIRES:** ___/___/___ **PHONE:( )** _____

ENROLLMENT DATE CORRESPONDS TO DATE BCCP ELIGIBILITY AND CONSENT FORM SIGNED.

INSURANCE STATUS: ☐ Uninsured (refer to https://www.BeWellNM.com) ☐ Underinsured (screening and/or diagnostic services not included in plan)

Hispanic/Latino Origin: ☐ Yes ☐ No (Please identify Hispanic/Latino Origin AND one or more of the races listed below.)

Race (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Navajo ☐ American Sign Language ☐ Other American Indian ☐ Other: _____

Smoking Status: ☐Never ☐Former ☐Current **>>>** Referred to cessation services (e.g., 1-800-QUITNOW or www.quitnownm.org)? ☐No ☐Yes (includes all cessation services)

BREAST SECTION: For people already known to be at high risk for breast cancer, documentation of high-risk status is required when requesting prior authorization for high-risk breast cancer screening. Those with no personal history of breast cancer should undergo risk assessment to determine their breast cancer risk and guide appropriate screening.

1. Breast cancer risk status: info at BCCP website: https://www.nmhealth.org/about/phd/pchb/bcc/

☐ Personal history of breast cancer: no risk assessment is required, and appropriate surveillance guidelines should be followed.

☐ **High** *If one or more of the items below are true, no further risk assessment is required, and appropriate high-risk screening recommendation should be followed.*
- ☐ PRE-menopausal breast cancer among first-degree relative(s)
- ☐ Known genetic mutation such as BRCA 1 or 2 (*the person/client or first-degree relative*)
- ☐ Had radiation treatment to chest between ages 10-30 years
- ☐ History of lobular neoplasia (LCIS), atypical lobular hyperplasia (ALH), ductal carcinoma in situ (DCIS), or atypical ductal hyperplasia (ADH)
- ☐ Personal or family history of certain genetic syndromes (e.g., Li-Fraumeni)

If none of the items above are true, check "Average" and obtain calculated risk score from mammogram report; if not provided by imaging facility, complete a breast cancer risk assessment tool to calculate the person's/client's lifetime risk for developing breast cancer.

- ☐ Calculated lifetime risk of 20% or more for developing breast cancer based on risk assessment model: **LIFETIME RISK =** _____**%** [enter percentage]

☐ **Average** per risk assessment model; breast cancer risk status should be reassessed periodically (e.g., during enrollment) because average risk status may change over time.

2. Currently lactating (breastfeeding)? ☐ No ☐ Yes

3. Breast symptoms reported by client? ☐ No ☐ Yes* >> How Long?_____

If yes, describe: _____

***** *Clinical breast exam (CBE) may be performed per clinician preference, but when there are symptoms, a CBE is required to guide potential referral for diagnostic services.*

CURRENT CLINICAL BREAST EXAM (CBE) RESULTS/INFORMATION:

CBE done today? ☐ No ☐ Yes >>> Date: ___/___/___

☐ Normal/Benign (including fibrocystic changes) ☐ Not needed ☐ Declined

4. Does the person/client have breast implants?

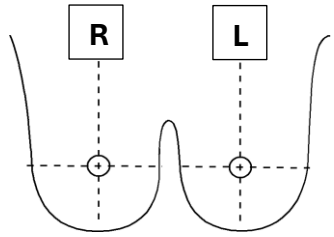
☐ No

☐ Yes >>> If yes: ☐ Bilateral ☐ Unilateral >>> ☐ Left Side ☐ Right Side

MARK POSITIVE FINDINGS BELOW AND SHOW LOCATION AND SIZE ON BREAST DIAGRAM.
If symptomatic or positive findings, follow current NCCN Guidelines® (http://www.nccn.org/) **.

☐ **Palpable mass**

☐ **Nipple discharge:** ☐ **Unilateral** ☐ **Bilateral**
- **Spontaneous?** ☐ **No** ☐ **Yes**
- **Expressed on exam?** ☐ **No** ☐ **Yes**
- **If yes: Color?** _____
  - **Bloody?** ☐ **No** ☐ **Yes**
  - **Single Duct?** ☐ **No** ☐ **Yes**



☐ **Asymmetrical thickening or nodularity**

☐ **Skin changes (peau d'orange, erythema, nipple excoriation, scaling, eczema, skin ulcers)**

****** *Although NCCN Guidelines® may recommend diagnostic evaluation and follow-up for those under age 30, the BCC Program cannot reimburse for these services for average risk people.*

PRIOR AUTHORIZATION (PA) REQUIRED FOR: HIGH RISK BREAST CANCER SCREENING (I.E., SCREENING BREAST MRI), BREAST WORK-UP IF AGE 30-39 YEARS, DIAGNOSTIC MRI, MAMMARY DUCTOGRAM, CHEST WALL BIOPSY, AXILLARY LYMPH NODE BIOPSY.

CERVICAL SECTION: All individuals must be assessed for their cervical cancer risk using the criteria in #1 below to guide appropriate screening.

1. Cervical cancer risk status: info at BCCP website: https://www.nmhealth.org/about/phd/pchb/bcc/

☐ High (history of cervical cancer, had *in utero* DES exposure, and/or is immunocompromised (e.g., HIV positive))
☐ Above Average (patient has history of CIN2 or greater but does not meet "high" risk criteria above)
☐ Average

2. Ever had a Pap and/or HPV test before today?

☐ No/Never
☐ Yes >>> Date of last Pap/HPV test: ___/___/___

IF UNSURE OF DATE, MUST PROVIDE BEST GUESS FOR MONTH AND YEAR OF LAST PAP/HPV TEST.

3. Pregnant now? ☐ No ☐ Yes >>> estimated due date: ___/___/___
4. Hysterectomy? ☐ No ☐ Yes >>> hysterectomy for cervical cancer? ☐ No ☐ Yes
5. Intact cervix? ☐ No ☐ Yes

Current USPSTF cervical cancer screening recommendations for average risk women with normal results are: screening with Pap test alone every 3 years for ages 21-65 years; or, for ages 30-65 years, screening with high-risk HPV test alone (primary HPV testing) every 5 years, or screening with both a Pap test and HPV test together (co-testing) every 5 years.

CURRENT CERVICAL EXAM RESULTS/INFORMATION: If Pap and/or HPV test done, must attach copy of cytology report with claim to request reimbursement.

Pap test done today? ☐ No ☐ Yes >>> Date: ___/___/___

If yes, is today's Pap test to follow-up a previous abnormal Pap test?

☐ No ☐ Yes >>> Date of previous abnormal: ___/___/___

HPV test done today? ☐ No ☐ Yes >>> Date: ___/___/___

If HPV test done today, complete reason for test below:

☐ Co-test (in combination with screening Pap test)

☐ Primary Screening (HPV test alone)

If Pap and/or HPV test(s) not done today, complete reason(s) below:

☐ Not needed ☐ Done recently elsewhere
☐ Declined ☐ Needed, not performed >>>

Initiate cervical cancer screening reminder in electronic medical record.

PRIOR AUTHORIZATION (PA) REQUIRED FOR: CERVICAL DIAGNOSTIC EXCISIONAL PROCEDURES (I.E., LEEP, COLD-KNIFE CONIZATION), FURTHER EVALUATION OF VISIBLE CERVICAL LESIONS WHEN PAP TEST RESULT IS NORMAL, AND POST CERVICAL CANCER SURVEILLANCE.

Was client enrolled in the BCCP for referral to diagnostic services only? ☐ **No** ☐ **Yes >>> Date of referral:** ___/___/___ *ENROLLMENT DATE CORRESPONDS TO DATE BCCP ELIGIBILITY AND CONSENT FORM SIGNED.*

REFERRAL/ORDERS: Use the space below to complete referral/orders for additional breast and/or cervical cancer screening and/or diagnostic services within the BCCP Provider Network.

Please bring this form to your appointment(s) listed below. **Por favor traiga esta forma a la(s) cita(s) mencionada(s) debajo.**

Referral/Order for: _____ **Appointment date:** ___/___/___
Time: **Facility:** **Doctor:**
Address: **Phone: ( )**

Referencia/Orden para: _____ **Fecha de la cita:** ___/___/___
Hora: **Clínica:** **Médico:**
Dirección: **Teléfono: ( )**

Referral/Order for: _____ **Appointment date:**
Time: **Facility:** **Doctor:**
Address: **Phone: ( )**

Referencia/Orden para: _____ **Fecha de la cita:** ___/___/___
Hora: **Clínica:** **Médico:**
Dirección: **Teléfono: ( )**

PROVIDER SIGNATURE: _____ **DATE:** ___/___/___

[Revised July 2025]