

**WISCONSIN WELL WOMAN PROGRAM
 BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF)**

INSTRUCTIONS: Before completing this form, refer to the Breast and Cervical Cancer Screening Activity Report (ARF) Instructions, F-44723I. For reimbursement, mail the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I – BILLING PROVIDER INFORMATION

1. Provider ID	2. Name – Billing Provider	3. Taxonomy Code	4. Practice Location Zip+4 Code
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SECTION II – CLIENT PERSONAL INFORMATION

5. Last Name – Client	6. First Name – Client	7. Middle Initial – Client
8. Previous Last Name – Client	9. Client ID Number	10. Date of Birth – Client (MM/DD/CCYY)

SECTION III – BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY	MAMMOGRAM
11. Previous Mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	21. Indication for Initial Mammogram <input type="checkbox"/> Screening <input type="checkbox"/> Non-Program Mammogram; Referred for Diagnostic Evaluation
12. Date of Previous Mammogram (MM/DD/CCYY)	22. Date of Breast Diagnostic Referral (MM/DD/CCYY)
13. Client Currently Reporting Breast Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23. High Risk for Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed / Unknown
OFFICE VISIT WITHOUT CBE ONLY	24. Date of Initial Mammogram (MM/DD/CCYY)
14. Date of Office Visit (MM/DD/CCYY)	25. Name – Rendering Provider (Print)
15. Name – Rendering Provider (Print)	26. Mammogram Result (Check One Box Only)
16. Result (Check One Box Only) <input type="checkbox"/> Follow-up Needed <input type="checkbox"/> No Follow-up Needed	<input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign – Short Term Follow-up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality – Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete – Findings Require Additional Evaluation (BI-RADS 0) <input type="checkbox"/> Need Evaluation or Film Comparison (BI-RADS 0) <input type="checkbox"/> Unsatisfactory – Mammogram Was Technically Unsatisfactory and Could Not Be Interpreted by Radiologist
CLINICAL BREAST EXAM (CBE)	Shading indicates additional follow up for WWWP
17. Purpose of CBE (Check One Box Only) <input type="checkbox"/> Screening <input type="checkbox"/> Repeat	BREAST FOLLOW-UP RECOMMENDATIONS
18. Date of CBE (MM/DD/CCYY)	27. Recommendation(s)
19. Name – Rendering Provider (Print)	<input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short Term Follow-up _____ Months <input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Film Comparison to Evaluate an Assessment Incomplete Mammogram <input type="checkbox"/> Additional Mammographic Views <input type="checkbox"/> Ultrasound <input type="checkbox"/> Breast Consultation <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Biopsy
20. Result (Check One Box Only) <input type="checkbox"/> Normal Exam <input type="checkbox"/> Benign Finding <input type="checkbox"/> Discrete Palpable Mass – Diagnosis Benign <input type="checkbox"/> Bloody or Serous Nipple Discharge <input type="checkbox"/> Nipple or Areolar Scaliness <input type="checkbox"/> Skin Dimpling or Retraction <input type="checkbox"/> Focal Pain or Tenderness <input type="checkbox"/> Discrete Palpable Mass – Suspicious for Cancer Shading indicates additional follow up for WWWP	

CERVICAL SCREENING HISTORY	HPV TEST
28. Prior Pap Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	41. Indication for HPV Test <input type="checkbox"/> Co-Test / Screening <input type="checkbox"/> Reflex
29. Date of Last Pap Test (MM/DD/CCYY)	42. Date of HPV Test (MM/DD/CCYY)
PELVIC EXAM	43. HPV Test Result (Check One Box Only) <input type="checkbox"/> Negative <input type="checkbox"/> Positive With Positive Genotyping (Types 16 or 18) <input type="checkbox"/> Positive With Negative Genotyping (HPV+, But Not Types 16 or 18) <input type="checkbox"/> Positive With Genotyping Not Done Shading indicates additional follow up for WWWP
30. Date of Pelvic Exam (MM/DD/CCYY)	
31. Name – Rendering Provider (Print)	
32. Result (Check One Box Only) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal – Not Suspicious for Cervical Cancer <input type="checkbox"/> Abnormal – Suspicious for Cervical Cancer Shading indicates additional follow up for WWWP	
PAP TEST	CERVICAL FOLLOW-UP RECOMMENDATIONS
33. Indication for Pap Test <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> Non-Program Pap; Referred for Diagnostic Evaluation <input type="checkbox"/> Pap After Primary HPV+	44. Recommendation(s) <input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short Term Follow-up _____ Months <input type="checkbox"/> HPV Test <input type="checkbox"/> Colposcopy With Biopsy <input type="checkbox"/> Colposcopy Without Biopsy <input type="checkbox"/> ECC Alone <input type="checkbox"/> Diagnostic LEEP <input type="checkbox"/> Diagnostic Cone <input type="checkbox"/> Endometrial Biopsy Only covered if Pap result is AGC <input type="checkbox"/> Hysterectomy Not covered by WWWP
34. Date of Cervical Diagnostic Referral (MM/DD/CCYY)	
35. Type of Pap Test (Check One Box Only) <input type="checkbox"/> Liquid Based <input type="checkbox"/> Conventional	
36. High Risk for Cervical Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed / Unknown	45. Notes
37. Date of Pap Test (MM/DD/CCYY)	
38. Name – Rendering Provider (Print)	
39. Adequacy of Pap Smear Specimen (Check One Box Only) <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	
40. Pap Result (Check One Box Only) <input type="checkbox"/> (NILM) Negative for Intraepithelial Lesion or Malignancy <input type="checkbox"/> Infection/Inflammation/Reactive Changes <input type="checkbox"/> (ASC-US) Atypical Squamous Cells of Undetermined Significance <input type="checkbox"/> (LSIL) Low-Grade SIL (Including HPV Changes) <input type="checkbox"/> ASC-H) Atypical Squamous Cells – Cannot Exclude HSIL (Beth 2001) <input type="checkbox"/> (HSIL) High-Grade SIL <input type="checkbox"/> (SCC) Squamous Cell Carcinoma <input type="checkbox"/> (AGC) Atypical Glandular Cells (Beth 2014) <input type="checkbox"/> (AIS) Adenocarcinoma in Situ (Beth 2014) <input type="checkbox"/> Adenocarcinoma (Beth 2014) Shading indicates additional follow up for WWWP	



F-44723