

**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 Completion Instructions, F-44723A. 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 — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth — Member (MM/DD/CCYY)

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY	CERVICAL SCREENING HISTORY
11. Previous Mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23. Prior Pap Test? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Date of Previous Mammogram (MM/DD/CCYY)	24. Date of Last Pap Test (MM/DD/CCYY)
13. Member Reports Breast Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PELVIC EXAM
CLINICAL BREAST EXAM	25. Date of Pelvic Exam (MM/DD/CCYY)
14. Purpose of CBE (Check One Box Only) <input type="checkbox"/> Screening <input type="checkbox"/> Repeat	26. Name — Rendering Provider (Print)
15. Date of CBE (MM/DD/CCYY)	27. 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 procedures needed to complete cervical cycle.
16. Name — Rendering Provider (Print)	
17. RESULT (Check One Box Only) <input type="checkbox"/> Normal Exam <input type="checkbox"/> Discrete Palpable Mass — Suspicious for Cancer <input type="checkbox"/> Benign Finding <input type="checkbox"/> Nipple or Areolar Scaliness <input type="checkbox"/> Discrete Palpable Mass — Dx Benign <input type="checkbox"/> Skin Dimpling or Retraction <input type="checkbox"/> Bloody or Serous Nipple Discharge Shading indicates additional procedures needed to complete breast cycle.	PAP TEST
MAMMOGRAM	28. Indication for Pap Test <input type="checkbox"/> Routine Pap Test <input type="checkbox"/> Patient under surveillance for a previous abnormal test. <input type="checkbox"/> Pap test done by a non-program funded provider, patient referred in for diagnostic evaluation. <input type="checkbox"/> Pap test not done. Patient proceeded directly for diagnostic work-up or HPV test.
18. Indication for Initial Mammogram <input type="checkbox"/> Routine Screening Mammogram <input type="checkbox"/> Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result. <input type="checkbox"/> Initial mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation. <input type="checkbox"/> Initial mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up (use Breast Cancer Diagnostic and Follow-Up Report [DRF], F-44724).	29. Date of Cervical Diagnostic Referral (MM/DD/CCYY)
19. Date of Breast Diagnostic Referral (MM/DD/CCYY)	30. Type of Pap Test (Check One Box Only) <input type="checkbox"/> Liquid based** <input type="checkbox"/> Conventional ** Reimbursed at rate of Conventional Pap Smear.
20. Date of Initial Mammogram (MM/DD/CCYY)	31. Date of Pap Test (MM/DD/CCYY)
21. Name — Rendering Provider (Print)	32. Name — Rendering Provider (Print)
22. RESULT (Check One Box Only) <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"/> Film Comparison Required (BI-RADS 0) <input type="checkbox"/> Unsatisfactory Shading indicates additional procedures needed to complete breast cycle.	33. ADEQUACY OF PAP SMEAR SPECIMEN (Check One Box Only) <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory
	34. RESULT (Check One Box Only) <input type="checkbox"/> AGC (Abnormal Glandular Cells Including Adenocarcinomas) <input type="checkbox"/> ASC-H (Atypical Squamous Cells [ASC-US Cannot Exclude HSIL]) <input type="checkbox"/> ASC-US (Atypical Squamous Cells Undetermined Significance) <input type="checkbox"/> High-Grade SIL (HSIL): Moderate and Severe Dysplasia, CIS / CIN 2 / CIN 3 <input type="checkbox"/> Low-Grade SIL Including HPV Changes (LSIL: HPV, Mild Dysplasia, CIN I) <input type="checkbox"/> Negative <input type="checkbox"/> Squamous Cell Carcinoma Shading indicates additional procedures needed to complete cervical cycle.

Continued



SECTION III — BREAST AND CERVICAL SCREENING (Continued)	
HPV TEST	CERVICAL FOLLOW-UP RECOMMENDATION
<p>The WWWW covers HPV test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.</p>	<p>38. Recommendations(s)</p>
<p>35. Date of HPV Test (MM/DD/CCYY)</p>	<p><input type="checkbox"/> Follow Routine Screening _____ Months</p>
<p>36. Result (Check One Box Only)</p> <p><input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>	<p><input type="checkbox"/> Short-Term Follow up _____ Months</p>
BREAST FOLLOW-UP RECOMMENDATION	<p><input type="checkbox"/> HPV Test</p>
<p>37. Recommendation(s)</p> <p><input type="checkbox"/> Follow Routine Screening _____ Months</p> <p><input type="checkbox"/> Short-Term Follow up _____ Months</p> <p><input type="checkbox"/> Film Comparison to Evaluate an Assessment Incomplete Mammogram</p> <p><input type="checkbox"/> Additional Mammographic Views</p> <p><input type="checkbox"/> Ultrasound</p> <p><input type="checkbox"/> Breast Consultation</p> <p><input type="checkbox"/> Fine Needle Aspiration</p> <p><input type="checkbox"/> Biopsy</p>	<p><input type="checkbox"/> Colposcopy with Biopsy</p> <p><input type="checkbox"/> Colposcopy Without Biopsy</p>
<p>39. Notes</p>	<p><input type="checkbox"/> ECC Alone</p> <p><input type="checkbox"/> Diagnostic LEEP</p> <p><input type="checkbox"/> Diagnostic Cone</p> <p><input type="checkbox"/> Endometrial Biopsy**</p> <p><input type="checkbox"/> Hysterectomy*</p> <p>* Not covered by WWWW.</p> <p>** Only covered if Pap result is AGC.</p>