

<p>MAINE BREAST AND CERVICAL HEALTH PROGRAM UPDATE FORM FOR PRIMARY CARE PROVIDERS</p>

1. Primary Care Site Name and Address of location where services are provided:

NAME:	
ADDRESS:	COUNTY:
CITY, STATE, ZIP:	
TELEPHONE:	FAX:
EMAIL:	

2. Name and address of ownership organization, if different from above:
(Note: The name indicated for payment must match that listed on the Federal W-9 Tax form)

NAME:	
ADDRESS:	
CITY, STATE, ZIP:	
TELEPHONE:	FAX:
EMAIL:	

3. Please check the appropriate block to indicate your provider type:

- Hospital Based
- Private Nurse Practitioners
- Federally Qualified Health Center
- Family Planning Center
- Private Physicians
- Rural Health Clinic
- Ambulatory Care Clinic

4. Service Providers:

Each primary care provider who wishes to participate in the Maine Breast and Cervical Health Program (MBCHP) must be listed below. **Please list names of all primary care providers (Physicians, Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives) whose services will be billed under this agreement.** Also, provide the date any previously reported servicing providers transferring from your site within the last year.

Name (first & last); Title and Email address	MaineCare Provider #	Specialty	Date Started	Date Left
1.				
2.				
3.				
4.				
5.				

Continue with additional names on the back of this form, if necessary

5. Billing Numbers:

<p><i>MaineCare Billing Provider Number:</i></p> <p>_____</p>

6. Which mammography facilities are your patients most likely to go to?

<p>_____ <i>Approximate %</i> _____</p> <p>_____ <i>Approximate%</i> _____</p>
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7. Name and address of cytology laboratory to which you currently send Paps:

Name:
Address:
City, State, Zip:
Telephone: _____ Fax: _____

8. Do you provide any of the following diagnostic services?

- Colposcopy
- Fine Needle Aspiration
- Breast Biopsy

If yes, are you willing to provide breast and cervical diagnostic services for patients that are not in your practice when referred by another MBCHP PCP?

- Yes
- No

If you provide any of these diagnostic services, which lab do you use?

Name:	Location:

9. Names, titles and telephone number of contact staff for the following:

_____	_____	_____
Enrollment Forms	Job Title	Telephone Number
_____	_____	_____
Visit Forms (Data)	Job Title	Telephone Number
_____	_____	_____
Abnormal Follow-up	Job Title	Telephone Number
_____	_____	_____
Billing	Job Title	Telephone Number
_____	_____	_____
Policy Updates should be mailed to	Job Title	Telephone Number

Signature of Provider or Administrator

Date