Breast & Cervical Cancer Control Navigation Program
Local Coordinating Agency #15

BC3NP REFERRAL & AUTHORIZATION FORM

Enrolled CLIENT NAME: _____ DATE OF BIRTH: _____

Enrollment/Screening SITE: _____ Enrollment DATE: _____

THE ABOVE NAMED CLIENT IS BEING REFERRED TO: _____
(Name of BC3NP Contracted Referral Site)

FOR / BREAST DIAGNOSIS: _____

TESTS ORDERED	**DATE Scheduled**	**COMMENT/Program**	**BC3NP AUTHORIZATION**
_____SCREENING MAMMOGRAM	_____	_____	Payable annually
_____DIAGNOSTIC MAMMOGRAM (Includes additional views)	_____	_____	1 in 12 months as follow-up
_____BREAST ULTRASOUND	_____	_____	1 in 12 months as follow-up
_____BREAST CONSULT	_____	_____	1 in 12 months as follow-up
_____BREAST BIOPSY	_____	_____	Payable if medically indicated
_____OTHER:_____	_____	_____	Authorization Questions Call BC3NP Local Coordinating Agency (LCA) Phone: 269-373-5383

THE ABOVE NAMED CLIENT IS BEING REFERRED TO: _____
(Name of BC3NP Contracted Referral Site)

FOR / CERVICAL DIAGNOSIS: _____

TESTS ORDERED	**DATE**	**COMMENT**	**BCCCNP AUTHORIZATION**
_____CERVICAL CONSULT	_____	_____	1 in 12 months as follow-up
_____CERVICAL BIOPSY	_____	_____	Payable if medically indicated
_____OTHER:_____	_____	_____	Authorization Questions Call BC3NP Local Coordinating Agency (LCA) Phone: 269-373-5383

TO ENSURE BC3NP PAYMENT:

Provider must **FAX / SEND RESULTS TO:**

BC3NP LCA at 269-373-5362 **and** REFERRING PROVIDER: _____

AGENCY NAME: _____

ADDRESS: _____

TELEPHONE / FAX NUMBERS: _____/_____

REQUESTING SIGNATURE: _____
Date

Billers use:

State of Michigan BC3NP Claims submission Information at: www.michigancancer.org/BCCCP
Unsure who to bill? Call LCA at 269-373-5213