Provider FEIN:_____

Service Month/Year:_____

Service Date Range:_____

BCC#:_____

Invoice #:_____

TYPED Provider Name and Address as it appears on W-9

WEST VIRGINIA BREAST & CERVICAL CANCER SCREENING PROGRAM 2024-2025 BATCH INVOICE FORM

Visit Type	CPT Code	Patient Fee %	Rate	Number of BPCCS Visits	Number of Visits x Rate	Amount Insurance Paid	Total Amount Paid
Initial Screening (15-29 min)	99202	0%	$67.79				
Initial Screening (30-44 min)	99203	0%	$105.98				
Initial Screening (45-59 min.)*	99204	0%	$159.75				
Initial Screening (60-74 min)*	99205	0%	$211.21				
Initial Comp Med Exam (18-39 yrs.)	99385	0%	$106.98				
Initial Comp Med Exam (40-64 yrs.)	99386	0%	$106.98				
Annual Routine Screening (20-29 min)	99213	0%	$85.87				
Annual Routine Screening (30-39 min)	99214	0%	$121.49				
Annual Breast or Cervical Screening (10-19 min)	99212	0%	$52.94				
Repeat Pap or CBE	99211	0%	$21.07				
Periodic Comp Med Exam (18-39 yrs)	99395	0%	$85.65				
Periodic Comp Med Exam (40-64 yrs)	99396	0%	$85.65				
Patient navigation only	G9012	NA	$50.00				
Patient Referral/Enrollment		NA	$25.00				
				Total Number of Visits:		Invoice Total:	

For payment of services under Agreement with the Bureau for Public Health, Office of Maternal, Child and Family Health, Breast and Cervical Cancer Screening Program, I certify that this is an original invoice and payment has not been received.

Full Signature for Verification **Title** **Date Submitted to WVBCCSP**

Return To: **WVBCCSP**
350 Capitol Street, Room 427
Charleston, WV 25301

Program Use Only

Invoice verified by documentation. I hereby certify that the items listed herein have been received and approved for payment.

Name: **Date:** **Batch #:**