Provider FEIN:
Service Month/Year:
Service Date Range:
BCCSP#:
Invoice #:

T

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

WEST VIRGINIA BREAST & CERVICAL CANCER SCREENING PROGRAM 2025-2026 BATCH INVOICE FORM

Visit Type	CPT Code	Patient Fee %	Rate	Number of BCCSP	Number of Visits x Rate	Amount Insurance	Total Amount Paid
Initial Screening (15-29 min)	99202	0%	$65.44				
Initial Screening (30-44 min)	99203	0%	$103.54				
Initial Screening (45-59 min.)*	99204	0%	$156.07				
Initial Screening (60-74 min)*	99205	0%	$206.78				
Initial Comp Med Exam (18-39 yrs.)	99385	0%	$103.54				
Initial Comp Med Exam (40-64 yrs.)	99386	0%	$103.54				
Annual Routine Screening (20-29 min)	99213	0%	$84.00				
Annual Routine Screening (30-39 min)	99214	0%	$118.76				
Annual Breast or Cervical Screening (10-19 min)	99212	0%	$51.29				
Repeat Pap or CBE	99211	0%	$20.47				
Periodic Comp Med Exam (18-39 yrs)	99395	0%	$84.00				
Periodic Comp Med Exam (40-64 yrs)	99396	0%	$84.00				
Pelvic Examination (list separately, in addition to primary procedure)	99459	0%	$17.84				
Patient Navigation	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.

Billing

Full Signature for Verification:_____ **Title:**_____ **Date Submitted:** ___ ___ _____

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 #:** _____