Provider FEIN:

Service Month/Year:

Service Date Range:

BCC#:

Invoice #:

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

WEST VIRGINIA BREAST & CERVICAL CANCER SCREENING PROGRAM 2026-2027 BATCH INVOICE FORM

Visit Type	CPT Code	Patient Fee %	Rate	Number of BCCSP Visits	Number of Visits x Rate	Amount Insurance Paid	Total Amount Paid
Initial Screening (15-29 min)	99202	0%	$70.69		-		-
Initial Screening (30-44 min)	99203	0%	$112.17		-		-
Initial Screening (45-59 min.)*	99204	0%	$170.01		-		-
Initial Screening (60-74 min)*	99205	0%	$227.86		-		-
Annual Breast or Cervical Screening (10-19 min)	99212	0%	$55.85		-		-
Annual Routine Screening (20-29 min)	99213	0%	$90.10		-		-
Annual Routine Screening (30-39 min)	99214	0%	$128.87		-		-
Repeat Pap or CBE	99211	0%	$22.16		-		-
Pelvic Examination (list seperately, in addition to primary procedure)	99459	0%	$15.09		-		-
Patient Navigation	G9012	NA	$50.00		-		-
Patient Referral/Enrollment		NA	$25.00		-		-
			Total Number of Visits:	0		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 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 #:**