West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH | Office of Maternal, Child and Family Health

West Virginia Breast and Cervical Cancer Screening Program Referral Form

West Virginia Breast & Cervical Cancer Screening Program
You're Worth It

All results along with breast or Cervical Diagnostic Reports must be mailed to the screening provider and a copy must be forwarded with the invoice to the WVBCCSP. See bottom of form for the WVBCCSP address.

Screening Facility: _____ **BCCSP#:** _____

Screening Clinician: _____ **Date referred:** _____/_____/_____

Telephone: _____-_____-_____

Client Name (Last, First, MI): _____ **DOB:** _____/_____/_____ **Social Security #:** _____

Referral

Provider Receiving Referral: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____- _____- _____

Date Appointment: ___ /_____ /_____ **Time:** _____

***Reimbursement is limited to the CPT Codes in the BCCSP Fee Schedule**

Breast Referral for:

- ☐ Screening Mammogram bilateral
- ☐ Screening Mammogram unilateral
- ☐ Diagnostic mammogram bilateral
- ☐ Diagnostic mammogram unilateral
- ☐ Surgical consultation
- ☐ Fine needle aspiration
- ☐ Puncture aspiration of cyst
- ☐ Breast biopsy
- ☐ Ultrasound

Cervical Referral for:

- ☐ Colposcopy with biopsy
- ☐ Loop electrode excision procedure (LEEP) of cervix
- ☐ Colposcopy with biopsy and endocervical curettage
- ☐ Colposcopy with endometrial curettage
- ☐ Colposcopy with loop electrode conization of the cervix
- ☐ Cervical biopsy or local excision of lesion
- ☐ Conization of cervix with or without repair
- ☐ Endometrial biopsy in conjunction with colposcopy
- ☐ Colposcopy with loop electrode biopsy
- ☐ Endocervical curettage (not done as part of D&C)

Clinical breast exam (CBE): ☐ Yes ☐ No

Date Performed: ____/____ /_____

CBE Results:

- ☐ Normal Exam/Benign finding
- ☐ Bloody/Serous Nipple Discharge
- ☐ Discrete Palpable mass
- ☐ Skin dimpling/ Retraction
- ☐ Nipple/Areolar scaliness
- ☐ Focal pain and tenderness

Most recent: ☐ Pap test ☐ HPV test

Date Performed: _____/_____ /_____

Facility that performed test: _____

Indication for colposcopy

Check all that apply

Pap Test / HPV Test Results:

- ☐ LSIL
- ☐ HSIL
- ☐ ASC-H
- ☐ AIS
- ☐ HPV +
- ☐ ASC-US (with a +, high-risk HPV test)
- ☐ Squamous cell carcinoma
- ☐ Adenocarcinoma
- ☐ AGC

***A copy of the test report must be attached to this form.**

Paid for by WVBCCSP ☐ **Yes** ☐ **NO**

I understand that I have met the eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). I may have health insurance and still be eligible for this referral to be paid for fully or partially by the WVBCCSP. My insurance will be billed first. I also understand that the program will not cover pre-operative testing and certain other procedures that may be ordered. I will take this referral form to the physician or facility named above when I go to my appointment.

Patient Signature: _____ **Date:** _____/_____/ _____

Original: Provider Copy: WVBCCSP Copy: Screening Provider Copy: Patient WVBCCSP Form # Y202 Rev. 03/2026

Send to WVBCCSP 350 capitol street, Room 427, Charleston VW 25301 Tel: (304) 558-5388 or 1-800-642-8522