TN Department of Health

Tennessee Breast & Cervical Screening Program

TBCSP Referral Form

Client Name: _____	**Referred to**:
DOB: _____	Physician / Facility: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

Scheduled Appointment Date: _____ **Time**: _____

Clinical Information: _____

Breast Implants: **Y** / **N** History of Breast Cancer: **Y** / **N** Interpreter needed: **Y / N** If yes, language: _____

SCHEDULED EXAMS

No Prior Authorization or Approval Required	*Additional Authorization or Approvals Required*
( ) Screening Mammogram	( ) Screening Breast MRI **With / Without Contrast**
( ) **Left** / **Right / Bilateral** Diagnostic mammogram & Ultrasound if indicated	( ) **Left / Right / Bilateral** Diagnostic MRI (Not TennCare Eligible*) requires CO approval** **With / Without Contrast**
( ) Breast Ultrasound (Diagnostic mammogram if medically indicated)	( ) LEEP (Not TennCare Eligible) required CO approval
( ) Core Needle Biopsy and/or Needle Aspiration **Left** / **Right**	( ) LEEP (TennCare Eligible) enroll in TennCare
( ) Ductogram	( ) Other Procedures: _____
( ) Colposcopy	*Patients eligible for TennCare must be enrolled by local Health Department
( ) Consult	**TBCSP and TennCare do not pay for MRIs to assess breast implant integrity

CLIENT INSTRUCTIONS

This appointment will be paid by the Tennessee Breast and Cervical Screening (TBCSP) Program. This authorization is only for the clinic visit or exam as indicated above. Additional appointments and procedures will require additional authorization. Follow up breast exams, cytology and/or HPV testing must be completed at/or approved by the referring provider.

Take a photo id and list of medications to appointment. If you are going to a surgical consult for breast issues, pick up your mammogram and/or ultrasound films to take with you to your appointment.

TBCSP is a limited services assistance program. Any blood work, additional testing or procedures **may not** be covered by TBCSP. Please verify with the provider that any tests done are necessary for the visit you have been scheduled for. If a surgical procedure is recommended, you **MUST** contact the health department first for a TennCare Presumptive Eligibility assessment. If you fail to do this, any charges or fees will be your responsibility.

PROVIDER INSTRUCTIONS

**Completion of this form assumes client's eligibility into TBCSP and the presence of a signed, current consent form*

Submit billing to:
710 James Robertson Pkwy
8th Floor, Attn: TBCSP
Nashville, TN 37243

Submit all reports to:
(Health Department/Clinic Label or Stamp)

Clinic Staff: _____ **Date:** _____
PRINT / SIGN