

**Wisconsin Well Woman Program
Breast and Cervical Cancer Screening Activity Report (ARF)**

Instructions

Before completing this form, refer to the Breast and Cervical Cancer Screening Activity Report (ARF) Instructions, F-44723I. For reimbursement, mail the claim and this completed form to Wisconsin Well Woman Program (WWWP), PO Box 6645, Madison, WI 53716-0645.

Section I: Billing provider information

1. Provider ID: _____
2. Name – billing provider: _____
3. Taxonomy code: _____
4. Practice location+4: _____

Section II: Client personal information

5. Last name – client: _____
6. First name – client: _____
7. Middle initial – client: _____
8. Previous last name – client: _____
9. Client ID number: _____
10. Date of Birth – client (MM/DD/CCYY): _____

Section III: Breast and cervical screening**Breast screening history**

11. Previous mammogram? ☐ Yes ☐ No ☐ Unknown
12. Date of previous mammogram (MM/DD/CCYY): _____
13. Client currently reporting breast symptoms? ☐ Yes ☐ No ☐ Unknown

Office visit without clinical breast exam (CBE) only

14. Date of office visit (MM/DD/CCYY): _____
15. Name – rendering provider (print): _____
16. Result (check one box only): ☐ Follow-up needed ☐ No follow-up needed

Clinical breast exam (CBE)

17. Purpose of CBE (check one box only): ☐ Screening ☐ Repeat
18. Date of CBE (MM/DD/CCYY): _____
19. Name – rendering provider (print): _____
20. Result (check one box only)

☐ Normal exam	☐ Nipple or areolar scaliness*
☐ Benign finding	☐ Skin dimpling or retraction*
☐ Discrete palpable mass – diagnosis benign*	☐ Focal pain or tenderness*
☐ Bloody or serious nipple discharge*	☐ Discrete palpable mass – suspicious for cancer*

* indicates additional follow-up for WWWP

Mammogram

21. Indication for initial mammogram:

☐ Screening ☐ Non-program mammogram; Referred for non-diagnostic evaluation

22. Date of breast diagnostic referral (MM/DD/CCYY): _____

23. High risk for breast cancer: ☐ Yes ☐ No ☐ Not assessed/unknown

24. Date of initial mammogram (MM/DD/CCYY): _____

25. Name – rendering provider (print): _____

26. Mammogram result (check one box only)

☐ Negative (BI-RADS 1)☐ Benign findings (BI-RADS 2)☐ Probably benign – short term follow-up
(BI-RADS 3)☐ Suspicious abnormality – consider biopsy
(BI-RADS 4)*☐ Highly suggestive of malignancy
(BI-RADS 5)*☐ Assessment incomplete – findings
require additional evaluation
(BI-RADS 0)*☐ Need evaluation or film comparison
(BI-RADS 0)*☐ Unsatisfactory – mammogram was
technically unsatisfactory and could not
be interpreted by radiologist*

* indicates additional follow-up for WWWP

Breast follow-up recommendations

27. Recommendations

☐ Follow-up routine screening _____
months☐ Short-term follow-up _____ months☐ Screening mammogram☐ Film comparison to evaluate an
assessment incomplete mammogram☐ Additional mammographic views☐ Ultrasound☐ Breast consultation☐ Fine needle aspiration☐ Biopsy**Cervical screening history**

28. Prior Pap test?

☐ Yes ☐ No ☐ Unknown

29. Date of last Pap test (MM/DD/CCYY): _____

Pelvic exam

30. Date of pelvic exam (MM/DD/CCYY): _____

31. Name – Rendering provider (print): _____

32. Result (check one box only)

☐ Normal☐ Abnormal – not suspicious for cervical cancer☐ Abnormal – suspicious for cervical cancer*

* indicates additional follow-up for WWWP

Pap test

33. Indication for Pap test

☐ Screening☐ Surveillance☐ Non-program Pap; referred for diagnostic
evaluation☐ Pap after primary HPV+

34. Date of cervical diagnostic referral (DD/MM/CCYY): _____

35. Type of Pap test (check one box only)

☐ Liquid-based ☐ Conventional

36. High risk for cervical cancer
☐ Yes ☐ No ☐ Not assessed/unknown
37. Date of Pap test (DD/MM/CCYY): _____
38. Name – rendering provider (print): _____
39. Adequacy of Pap smear specimen (check one box only)
☐ Satisfactory ☐ Unsatisfactory
40. Pap result (check one box only)
☐ (NILM) Negative for intraepithelial lesion or malignancy
☐ Infection/inflammation/reactive changes*
☐ (ACS-US) Atypical squamous cells of undetermined significance*
☐ (LSIL) Low-grade SIL (including HPV changes)*
☐ (ACS-H) Atypical squamous cells – cannot exclude HSIL (Beth 2001)*
☐ (HSIL) High-grade SIL*
☐ (SCC) Squamous cell carcinoma*
☐ (AGC) Atypical glandular cells (Beth 2014)*
☐ (AIS) Adenocarcinoma in situ (Beth 2014)*
☐ Adenocarcinoma (Beth 2014)*

* indicates additional follow-up for WWWP

HPV test

41. Indication for HPV test
☐ Co-test/screening ☐ Reflex
42. Date of HPV test (DD/MM/CCYY): _____
43. HPV test result
☐ Negative
☐ Positive with positive genotyping (types 16 or 18)*
☐ Positive with negative genotyping (HPV+, but not types 16 or 18)*
☐ Positive with genotyping not done*

* indicates additional follow-up for WWWP

Cervical follow-up recommendations

44. Recommendations
- | | |
|--|--|
| ☐ Follow routine screening _____ months | ☐ Diagnostic LEEP |
| ☐ Short-term follow-up _____ months | ☐ Diagnostic cone |
| ☐ HPV test | ☐ Endometrial biopsy (Only covered if PAP result is AGC) |
| ☐ Coloscopy with biopsy | ☐ Hysterectomy (Not covered by WWWP) |
| ☐ Coloscopy without biopsy | |
| ☐ ECC alone | |
45. Notes

