

Every Woman Matters Mammography Order

Every Woman Matters



Clinic: This form must be completed prior to receiving services

Facility: Send a copy of the dictated report to the ordering provider and EWM

4/2022

First Name	Initial	Last Name	Date of Birth	Age
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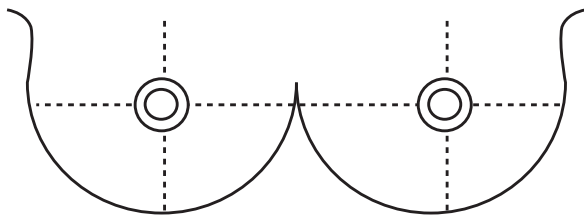
Clinic Site: _____ City: _____
(Please do not abbreviate)

This is an order for the above patient to receive the following:

- Screening Mammogram *(only covered for women 40 and over)*
- Diagnostic Mammogram *(only covered for women 30 and over)*
 Reimbursement for a diagnostic mammogram for clients 30-39 only with suspicious CBE or previous abnormal mammogram
- Breast Ultrasound
(No pre-approval necessary if ordered by a surgeon or radiologist following a diagnostic mammogram in clients 30-39. Please call 1-800-532-2227 if rural area and no surgeon available.)
- CHECK HERE IF ADDITIONAL STUDIES MAY BE PERFORMED AS DETERMINED BY THE RADIOLOGIST
(Per program policies as stated in Women's and Men's Health Program Provider Contract Manual)

RT

LT



Provider Remarks:

Provider's Signature: _____ Date: _____

Provider signature may serve as an order if facility allows.

Women's and Men's Health Programs - Every Woman Matters Program - 301 Centennial Mall South - P.O. Box 94817 - Lincoln, NE 68509-4817
 Toll-Free: 800.532.2227 - In Lincoln: 402.471.0929 - Fax: 402.471.0913 - Web: www.dhhs.ne.gov/EWM
 Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Part 1

Billing/Admissions/Patient Registration for Participating EWM Clients

1. This form is only used for EWM clients and should only be accepted by contracted EWM facilities.
2. Part 1 stays with the client to present to the Radiology Department. The Radiology Department can use Part 1 for tracking purposes.
3. Part 2 can be torn off and used for Billing/Admissions/Patient Registration purposes.

Client Name: _____

Date of Birth: ____/____/____

Part 2