Maxine S. Wright

AUTOBIOGRAPHY

I was born in the rural area of Aiken County, South Carolina. I now reside in Aiken County in a small town known as Bath. I live with my husband, David and our daughter LaDavia.

I graduated from Wagener Salley High School in Wagener, South Carolina in June 1973, And then I attended Aiken Technical College where I received my certification in phlebotomy.

In the year of 1989 I became a laboratory receptionist / phlebotomist for several years. During my latter years employed at Aiken Regional Hospital I became the Outpatient Supervisor.

As well as being employed at Aiken Regional Hospital I joined Rural Health Service in 2003 as a phlebotomist. In 2006 I became the laboratory manager. In 2012 I was given the task of taking over Best Chance Network for Rural Health Services.

Approximately, in the year of 2013 I was given the position BCN Coordinator for Rural Health Services. I now take pride in this position knowing that I am helping those who are uninsured to get the proper preventive health care needed. Now my job title stands as BCN Coordinator / Laboratory Manager.

BCN Coordinator, Maxine Wright

BEST CHANCE NETWORK ELIBILITY AND PROTOCCOL

Women between the ages of 30 – 64 must be a resident of South Carolina who are uninsured or with insurance with a high deductible of $1,000 or more And must meet income guidelines

1. Before any patients can be seen we must obtain a pre-authorization number from **BCN**. Forms must be filled out and scheduled for a date of service by the **BCN** Coordinator **Maxine Wright.**

2. Do not fax **BCN** a dummy date of service to obtain an authorization number. The date of Service must be scheduled with the **patient** before obtaining an authorization number.

3. All **pre-authorization forms** will then be forwarded to **Maxine Wright** or her delegate.

4. Once the **authorization codes** have been received from **BCN** it will be documented in the patient chart under encounter entry and notes for the front office and medical assistants.

5. The **authorization codes and approval** will be documented under the encounter in the patient chart. The **BCN authorization code** can also be located under scheduling and notes within the patient chart.

6. Be sure to document patient eligibility in their charts. **Example - CBE, Pelvic, Pap smear and Mammogram.**

7. Be sure to document everything the patient is **not eligible** for in the charts.

8. **Medical Assistants must flag all BCN Mammograms and Referrals** to the Coordinator for scheduling and processing.

9. All **Abnormal Pap's** and **Mammograms** must be **Flagged** to **Maxine Wright** the **BCN** Coordinator for processing and scheduling for further treatment.

10. It's **imperative** that you do **not** request an authorization number under any other employee name other than the **BCN** Coordinator.

11. It is imperative that you are entering the correct **providers codes** when requesting authorization numbers.

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Prior Authorization Code Request Form

Best Chance Network

To request a prior authorization (PA) code, complete this form and return it with a cover sheet. Failure to include a return fax number or email address may delay the issuance of a PA code.

Authorization Fax Lines: Toll Free: 1-866-297-6814
Authorization Phone Numbers: Toll Free: 1-866-297-6813

Are you enrolled as a Medicaid Provider? ☐ Yes ☐ No
Provider Code*: _____
Date: _____
Name of person requesting PA code: _____
Return PA codes to the provider by: ☐ Encrypted e-mail (Please provide e-mail address): _____
☐ Return Fax Number: _____

Chart #					
*Date of Service					
*First Name					
*Last Name					
*Date of Birth					
Social Security Number					
*Health Coverage Status: (Includes Private Insurance, Medicaid, and Medicare)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Healthy Connections Checkup Coverage	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Household Income	$_____ ☐ Weekly ☐ Monthly ☐ Annually	$_____ ☐ Weekly ☐ Monthly ☐ Annually	$_____ ☐ Weekly ☐ Monthly ☐ Annually	$_____ ☐ Weekly ☐ Monthly ☐ Annually	$_____ ☐ Weekly ☐ Monthly ☐ Annually
*Household Size					
*Lives in SC	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Checkup Client: Needs screening mammogram	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Checkup Client: Needs diagnostic services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*REQUIRED TO ASSIGN PA CODE

Best Chance Network
for women's cancer screening

Authorization Confirmation

DHEC will mark yes that clients are eligible for a pap but at the time of the visit you are responsible for verifying whether the client has had a hysterectomy and reason for hysterectomy.

- Total hysterectomy for non cervical cancer reason: No BCN Pap
- Total hysterectomy for cervical cancer: Pap/HPV annually
- Total hysterectomy for unknown reason: General Pap/HPV guidelines
- Partial hysterectomy, cervix intact: General Pap/HPV guidelines
- Partial hysterectomy, cervix not intact: No BCN Pap

Provider:	000045 - Margaret Weston Health Center-Clearwater
Authorization for:	**BCC** - Client is **Due** for Office Visit (CBE and Pelvic) - Client is **Due** for Pap Test - Client is **Due** for Mammogram
Due Dates:	Office Visit Regular - **02/06/2017** Mammography Regular - **02/06/2017** Pap Test Regular - **02/06/2017**
Client Name:	
SSN:	
Authorization Code:	
Date of Service:	02/27/2017
Who Created Authorization Code:	
Date Authorization Code was Created:	02/06/2017

D H E C
PROMOTE PROTECT PROSPER

Best Chance Network Screening/Billing Form

Best Chance Network
for women's cancer screening

Authorization Number

Service Date: ____/____/____ (MM DD YYYY)

Chart Number: _____

Type of Visit:
- ☐ Routine (New BCN Client or Annual Rescreen)
- ☐ Re-Visit (counseling or repeat Pap smear or symptoms between routine screening visits)
- ☐ Routine (Healthy Connections Checkup Client)
- ☐ Report Only

(Provider Label may be placed here)
Provider FTN:
Contract Facility Name:
Clinic Name:
Provider Code:

A. Client Data

Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: ____/____/____ (MM DD YYYY)

Address: _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zip Code)

Social Security Number: _____ Phone: (_____)_____-_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

United States Citizen: (Does NOT impact eligibility) ☐ Yes ☐ No

Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Asian ☐ Pacific Islander ☐ Native American

Income:
☐ Weekly ☐ Monthly ☐ Annual
$ _____

Household Size (including self):

Insurance: ☐ No Private insurance, No Medicaid, No Medicare ☐ Hospitalization Only ☐ Underinsured

Cost Explanation and Privacy Notice signed:
☐ Yes ☐ No

Is this client limited in any activities due to (Check all that apply):
- ☐ No Limitation ☐ Severe Hearing Loss ☐ Severe Vision Loss ☐ Other (please specify) _____
- ☐ Chronic Disease (heart disease, lung disease, kidney failure, diabetes, etc.)
- ☐ Intellectual Disability (brain/head injury, mental retardation, autism, etc.)
- ☐ Physical Disability (spinal cord injury, MS, ALS, amputation, MD, Spina Bifida, Cerebral Palsy, severe arthritis, etc.)

B. Tobacco Status

Is client a smoker or tobacco user? ☐ No ☐ Yes

If yes, was client referred to the SC Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669)? ☐ Yes ☐ Yes, client refused ☐ No

C. Health Insurance Marketplace Referral

Was client referred to the Health Insurance Marketplace? ☐ Yes ☐ No ☐ Exempt (Have limited income.)

D. Breast Screening Data

History:
- ☐ BRCA gene mutation
- ☐ BRCA gene mutation in first-degree relative
- ☐ Lifetime risk >20-25% (Claus, Tyrer-Cuziak, BRCAPRO, or BOADICEA model)
- ☐ Personal history of breast cancer

(If one or more checked, then you may refer for mammogram and breast MRI)

Breast Symptoms? ☐ Yes ☐ No

Mastectomy? ☐ Yes ☐ No

Prior Mammogram? ☐ Yes ☐ No Date: ____/____/____ (MM DD YYYY)

CBE Result: **(required for payment)**
- ☐ Normal ☐ Benign findings, NOT suspicious for cancer
- ☐ ***Discrete palpable mass, suspicious for cancer**
- ☐ ***Suspicious nipple discharge**
- ☐ ***Nipple or areolar scaliness**
- ☐ ***Skin dimpling, retraction or thickening**

*Requires referral for diagnostic mammogram and ultrasound

	Refused	Ordered	Appointment Date: (MM DD YYYY)
Screening Mammogram	☐	☐	____/____/____
Diagnostic Mammogram	☐	☐	____/____/____
Ultrasound	☐	☐	____/____/____
Breast MRI	☐	☐	____/____/____

Follow-Up (Check all that apply)
- ☐ Diagnostic mammogram ☐ Ultrasound ☐ MRI
- ☐ Breast Cyst Aspiration
- ☐ Biopsy ☐ Surgical Referral
- ☐ Date of first follow-up appointment ____/____/____ (MM DD YYYY)

Follow-up Site: _____

☐ Lost to Follow-up ☐ Refused Date: ____/____/____ (MM DD YYYY)

E. Cervical Screening

History: ☐ Cervical cancer ☐ DES in-utero ☐ CIN2/CIN3

Immunocompromised: ☐ Yes ☐ No

Post Menopause: ☐ Yes ☐ No

Prior Pap Smear? ☐ Yes Date ____/____/____ (MM DD YYYY) ☐ No

Hysterectomy? ☐ Yes Date ____/____/____ (MM DD YYYY) ☐ No

Cervix present ☐ Yes ☐ No

Reason:
- ☐ Cervical Cancer
- ☐ CIN2/CIN3
- ☐ Unknown
- ☐ Not for cervical cancer
- ☐ Other _____

Pelvic Exam Result: (required for reimbursement of $20.00)
- ☐ Normal
- ☐ Abnormal – NOT suspicious for cervical cancer
- ☐ Abnormal – suspicious for cervical cancer (requires follow up)
- ☐ Client Refused ☐ Provider did not offer
- ☐ Delayed Date ____/____/____ (MM DD YYYY)

Pap Test / HPV Test
- ☐ Performed ☐ Pap test performed ☐ HPV test performed
- ☐ Refused ☐ Not Needed ☐ Delayed Date: ____/____/____

Abnormal Pap/HPV or Pelvic Requires Follow-up
- ☐ Referred

Follow-up Site: _____

☐ Lost to Follow-up ☐ Refused Date: ____/____/____ (MM DD YYYY)

F. Counseling

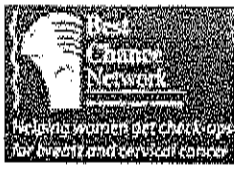
- ☐ Abnormal Breast Diagnosis ☐ Abnormal Mammogram ☐ Abnormal Pap Smear/HPV ☐ Abnormal U/S, Additional Views, MRI
- ☐ Biopsy by Radiologist ☐ Medicaid Application

G. Patient Navigation

Fax within 48 hours referral to BCN PA Line 1-866-297-6814

Patient Navigation Needed: ☐ No ☐ Yes: Referred to in-house patient navigation ☐ Yes: Referred to BCN patient navigation Referral date: ____/____/____ (MM DD YYYY)

Form Completed By: _____ Date Completed: _____


BCN MEDICAL ASSISTANTS QUESTIONAIRE

IT'S IMPERATIVE THAT THE QUESTIONS BELOW BE ANSWERED AND DOCUMENTED INTO EVERY BCN PATIENTS CHARTS UPON THEIR VISITS. THESE QUESTIONS MUST BE ANSWERED TO RECEIVE PAYMENT FROM BCN.

BCN DEALS SPECIFICALLY WITH THE BREAST AND CERVICAL FINDING

Breast Symptoms (Yes or No)

Last Mammogram (Month / Date / Year) _____

Last Pap Smear (Month / Date / Year) _____

Patient Limitation (Any Form of Disability) Yes or No

Tobacco User (Yes or No)

BRCA Gene mutation (Yes or No)

History of Breast Cancer (Yes or No)

History of Cervical Cancer (Yes or No)

Breast Symptoms (Yes or No)

Mastectomy Right_____Left_____

Post Menopause (Yes or No)

Previous Breast Cancer (Yes or No)

Mastectomy Right or Left

Post-Menopausal (Yes or No)

Hysterectomy (Yes or No) (Month / Date / Year)

Was Hysterectomy Due to Cervical Cancer (Yes or No) **(IF YES PAP SMEAR IS NEEDED)**

Partial Hysterectomy is Cervix Present (Yes or No)

Clinical Breast Exam (Normal or Suspicious Finding).....Per Provider
Pelvic and Cervix Exam.....Per Provider
Cervix Present (Yes or No).....Per Provider

Pelvic and Cervical Exam (Normal or Abnormal for Suspicious Finding) BCN Specifically wants the Pelvic and Cervical Exam documentation. **Normal or abnormal uterus documentation.**

BCN DEALS SPECIFICALLY WITH THE BREASTS AND CERVICAL FINDING.

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Best Chance Network
Cervical Follow-up/Billing Form

3. Provider Site Label:

1. Service Date ____-____-_____ Chart # _____
   MM DD YYYY
2. Type of Visit: ☐ First BCN Visit to this office ☐ Follow-up Visit (including counseling) ☐ Report Only /Non-BCN Funded Services

A. PATIENT INFORMATION (Please Print Clearly)

4. Name: _____ 5. Birthdate: ____-____-_____
   Last First MM DD YYYY
6. Last Four Digits of Social Security Number or Med-IT Number: _____

B. PELVIC EXAM & PAP SMEAR RESULTS

7. **Pelvic Exam Results:**
   ☐ Normal ☐ Abnormal - not suspicious for CIN or cancer
   ☐ Abnormal - suspicious for CIN or Cervical Cancer

Pap Specimen Adequacy:

8. ☐ Satisfactory ☐ Unsatisfactory
   requires a repeat Pap date **Repeat Pap Date** ___/___/_____
9. **Pap Smear Results (Bethesda 2002)**
   ☐ Negative for Intraepithelial Lesion or Malignancy
   ☐ Atypical Squamous Cells of Undetermined Significance (ASC-US) (may test for HPV DNA)
   ☐ Low-Grade Squamous Intraepithelial Lesions including (HPV & CIN I) (may require follow-up)

Cervical Follow-up Required for the Following:

☐ Atypical Squamous Cells, cannot exclude High-Grade SIL (ASC-H)
☐ High-Grade Squamous Intraepithelial Lesions: Moderate & Severe Dysplasia: CIS, CIN2 and CIN3
☐ Squamous Cell Carcinoma
☐ Abnormal Glandular Cells including: Adenocarcinoma in situ and Adenocarcinoma
☐ Other (specify) _____
☐ Refused

10. **HPV DNA** ☐ Negative ☐ Positive

C. CERVICAL FOLLOW-UP

11. **Type of Procedures Performed and Date** ____/___/_____
    ☐ Colposcopy of Cervix without Biopsy.
    ☐ Colposcopy of Cervix with Biopsy of Cervix and Endocervical Currettage.
    ☐ Colposcopy of Cervix with Biopsy(s) of Cervix.
    ☐ Colposcopy of Cervix with Endocervical Currettage.
    ☐ Endometrial sampling (CPT code 58100*)
    ☐ Endometrial sampling (CPT code 58110*) with Colposcopy
    ***Must attach CMS 1500**
    ☐ LEEP

12. **Procedure Results**
    ☐ Normal/Benign/Inflammation
    ☐ HPV/Condyloma/Atypia
    ☐ CIN I – Mild Dysplasia
    ☐ CIN II Moderate Dysplasia based on Biopsy
    ☐ CIN III Severe Dysplasia/Carcinoma in situ based on biopsy
    ☐ Squamous Cell Cancer based on Biopsy
    ☐ Adenocarcinoma based on biopsy
    ☐ Other (specify) _____

C. CERVICAL FOLLOW-UP

13. **Biopsy Report(s) Attached** ☐ Yes
14. **Further Follow-up Needed**
    ☐ No
    ☐ Yes Pending Biopsy on ____/____/_____ ☐ onsite
    ☐ Refused MM DD YYYY
    ☐ Lost to Follow-Up
15. **Stage at Diagnosis if Squamous Cell or Adenocarcinoma**
    ☐ Stage 1 ☐ Stage 3
    ☐ Stage 2 ☐ Stage 4

C. CERVICAL TREATMENT

16. **Treatment**
    ☐ Treatment Started on ____/____/_____
    ☐ Refused MM DD YYYY
    ☐ Lost to Follow-up
    ☐ Pending ____/____/_____
    MM DD YYYY
    Referred: _____
    Facility
17. **Treatment Type**
    ☐ Cryosurgery (not therapy)
    ☐ Laser Treatment
    ☐ Cold/Knife Cone/Conization
    ☐ LEEP/LETZ
    ☐ Hysterectomy
    ☐ Other _____
    ☐ To Be Determined

17a. **Treatment Report Attached** ☐ Yes

D. COUNSELING

18. **Counseled On:**
    ☐ Abnormal Diagnostic Tests - CIN2 or CIN3 result, cancer, HSIL PAP test result prior to LEEP
    ☐ Treatment Options
    ☐ Medicaid Application
    ☐ Abnormal Pap Test
19. **Form Completion Date:** ____/____/_____
    MM DD YYYY
    Name & Title _____

The Health Insurance Portability and Accountability Act (HIPAA) requires that clients be given a copy of a notice of privacy practices which documents their rights related to the release of protected health information. This act allows for the release of health information when it will be used for treatment, payment, and operations.

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Best Chance Network Referral Form

Authorization Code: _____

Appointment Date: ____/____/____
MM DD YYYY

1. This is a referral for:
☐ Pap Smear ☐ Breast Exam ☐ Diagnostic Mammogram
☐ Mammogram ☐ FNA ☐ Surgical Consult
☐ HPV DNA Test ☐ Cervical F/U Consult ☐ Radiological Breast Biopsy
☐ Colposcopy/Cervical Biopsy/ECC ☐ Ultrasound

(Attach all reports. Inform patient to take her mammogram x-rays if she is referred to a breast follow-up facility.)

2. **Reason for Referral:** _____

Clinical Problem/Abnormal Test(s): _____

Follow-up Request: _____

_____

3. **Date of BCN Screening Visit:** ____/____/____
MM DD YYYY

4. **Patient Referred:** _____ **DOB:** ____/____/____
LAST NAME FIRST NAME MM DD YYYY

Address: _____
PO Box/Street City State Zip Code

Phone #: (____)_____ Social Security #: ____/____/____ County: _____

5. **Referred From:** _____
Facility

Address: _____
PO Box/Street City State Zip Code

Phone #: (____)_____ Fax #: (____)_____

6. **Referred To:** _____
Facility

Address: _____
PO Box/Street City State Zip Code

Phone #: (____)_____ Fax #: (____)_____

7. Person Completing Referral: _____ Date: ____/____/____
Name/Title MM DD YYYY

The Health Insurance Portability and Accountability Act (HIPAA) requires that clients be given a copy of a notice of privacy practices which documents clients' rights related to the release of protected health information. This act allows for the release of health information when it will be used for treatment, payment and operations.

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South Carolina Department of Health and Environmental Control

Best Chance Network
Case Management Intake Form

(Please fax referral and report to SC DHEC BCN PA Line 1-866-297-6814)

Case Management referrals are no longer required if your facility has their own process for following clients with abnormal screening results. Best Chance Network can assist with helping your client understand the need for or nature of follow-up procedures. You may refer if you determine your client lacks the knowledge, skills and support to obtain necessary services.

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:_____ Zip:_____

SSN#:_____ Patient's Home Phone #:_____

Patient's Work Phone #:_____

Referral Source: BCN Referring Facility:_____

Referred by:_____ Phone #:_____

Doctor's Name:_____

DOB:_____ Race:_____

Emergency Contact: Name:_____

Relationship to Client:_____ Home Phone #:_____ Work Phone #:_____

Test Results	Date
1. Mammogram-ACR Code 4 (Suspicious)	
2. Mammogram-ACR Code 5 (Highly Suggestive Malignancy)	
3. Breast Ultrasound-ACR Code 4 or 5, Solid Mass	
4. Pap Smear-Atypical Glandular Cells of Undetermined Significance (AGUS)	
5. Pap Smear-Low Grade Squamous Intraepithelial Lesion (If HPV negative, repeat co-testing in 12 months preferred.)	
6. Pap Smear-High Grade SIL (HGSIL)	
7. Pap Smear-Squamous Cells of Carcinoma/Adenocarcinoma	
8. Pap Smear-Atypical Squamous Cells of Undetermined Significance-can not exclude High Grade SIL (ASC-H)	
9. Positive HPV DNA Test. (do not refer if Pap result is negative)	
10. Pelvic Exam-Suspicious for Cervical Cancer	

Comments:

☐ Missed Follow-Up Appt. ☐ Refused Referral ☐ Unable to Contact

Follow-up Referral:_____ Follow-up Facility: Phone #:_____

Purpose of Follow-up Referral:_____ Date of Appointment:_____

BCN Staff taking referral:_____ Date:_____

Dear _____,

Our office has made a commitment to promote the health of its patients, and to provide education regarding preventive health measures that you can take to maintain a healthy lifestyle.

I am writing to ask you to call our office today to reschedule your Best Chance Network appointment. By getting mammogram and cervical screening tests regularly, can be found treated early when the chances for cure are best.

I have attempted to contact you by telephone. Unfortunately, I have not been able to reach you at the number we have on file. I am now attempting to contact you by letter asking you to call our office. We would like to discuss with you the results of your recent OBGYN visit.

Please contact me at your earliest convenience to reschedule your appointment.

You may contact me at (803) 380 – 7000 ext. 4281

Respectfully,

Maxine Wright, BCN Coordinator

Best Chance Network