SHOW ME Healthy Women

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

SHOW ME HEALTHY WOMEN PROVIDER TRAINING 2025

SHOW ME HEALTHY WOMEN

- ❑ Invoice Attestation
- ❑ Show Me Healthy Women Program (SMHW) Eligibility and Exclusion Criteria
- ❑ High-Deductible Insurance Requirements for Reimbursement
- ❑ Timeframes for Reimbursement Claims
- ❑ Missouri Health Strategies Architectures and Information Cooperative (MOHSAIC) Form Entry

Show Me Healthy Women

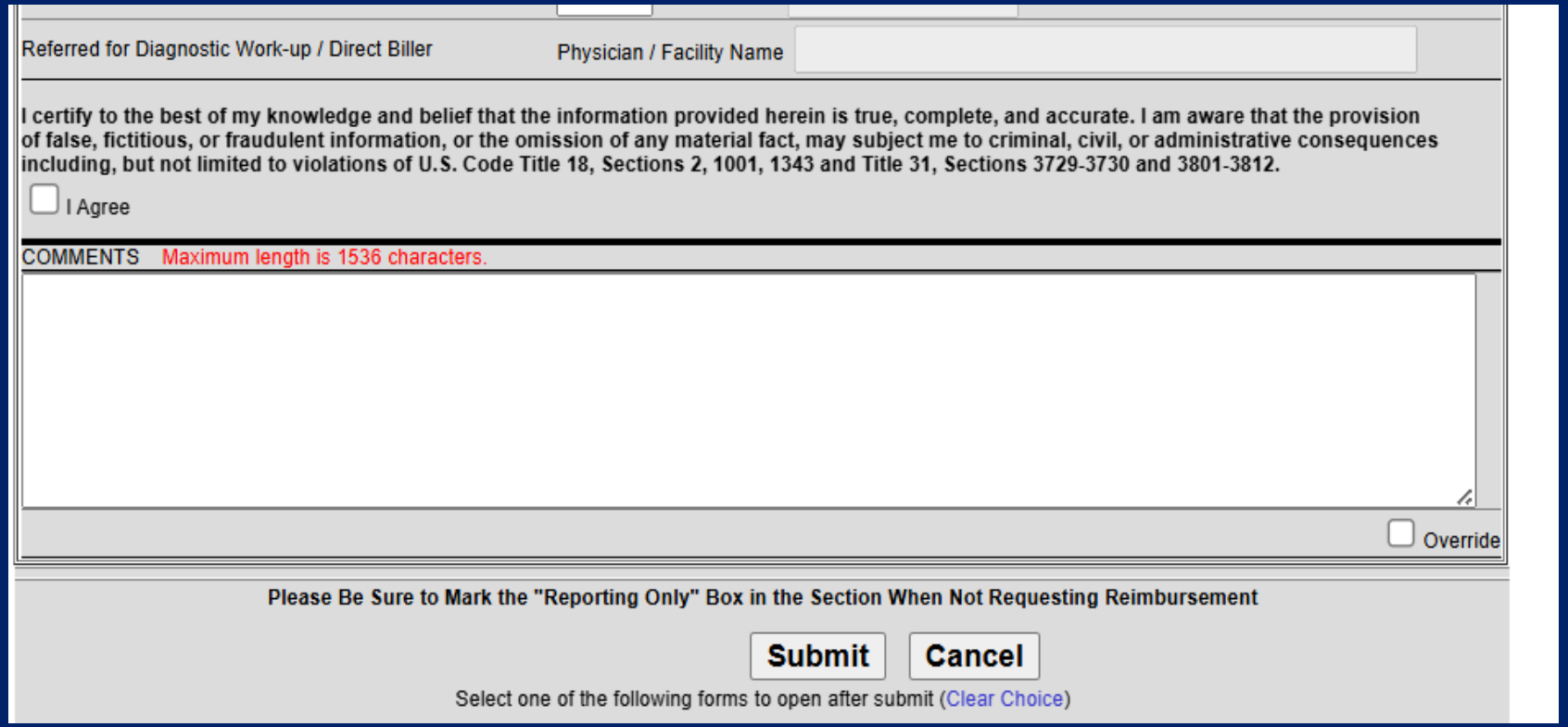
- ❑ MOHSAIC Visit Types
- ❑ SMHW Telehealth Visit
- ❑ CDC’s High-Risk Criteria for Breast and Cervical Cancer Screening
- ❑ Mammography Van Screening Information
- ❑ Breast and Cervical Cancer Treatment (BCCT) Guidelines

Show Me Healthy Women

- ❑ American Society for Colposcopy and Cervical Pathology (ASCCP) Information
- ❑ Transportation Voucher
- ❑ Patient Navigation
- ❑ Common Errors in Reimbursement Forms

ATTESTATION

Providers are required to attest to the following statement with each claim submission before reimbursement will be made.



SMHW ELIGIBILITY CRITERIA

- ❑ Females 21-64 years of age
- ❑ Meet Income Guidelines
- ❑ Underinsured or Not Insured

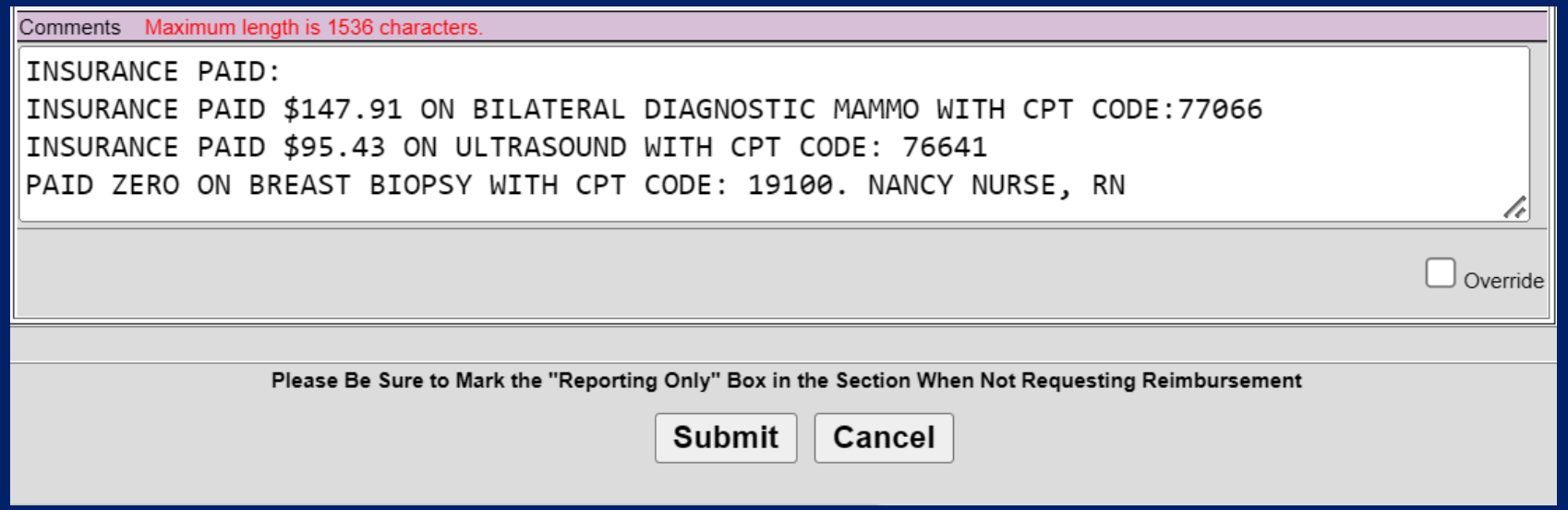
SMHW EXCLUSIONS

- ❑ Women with MO HealthNet (ME Code 05) or (ME Code E2)
- ❑ Women enrolled in prepaid/managed care and health plans, such as Health Maintenance Organizations [HMOs], Point of Service Plans [POS]
- ❑ Women with a current diagnosis of breast or cervical cancer are not eligible
- ❑ Women currently being treated for breast or cervical cancer are not eligible

HEALTH INSURANCE

- SMHW and WISEWOMAN programs are the payors of last resort
- SMHW and WISEWOMAN will reimburse the amount allowed per our guidelines, not above or in addition to
- The insurance must be billed first. Once the Explanation of Benefits (EOB) is received, list the dollar amount the insurance paid for each procedure with the corresponding CPT code in the comment section of the MOHSAIC reimbursement form

HIGH-DEDUCTIBLE HEALTH INSURANCE



BILLING TIMEFRAMES

Claims for reimbursement should be entered into MOHSAIC within **60** days of service

Claims submitted beyond **60** days may be considered ineligible for reimbursement

Submit final claims within **30** days of the grant year closing

BILLING TIMEFRAMES

- Claims submitted after the deadline cannot be reimbursed by SMHW or billed to the client

Reminder:

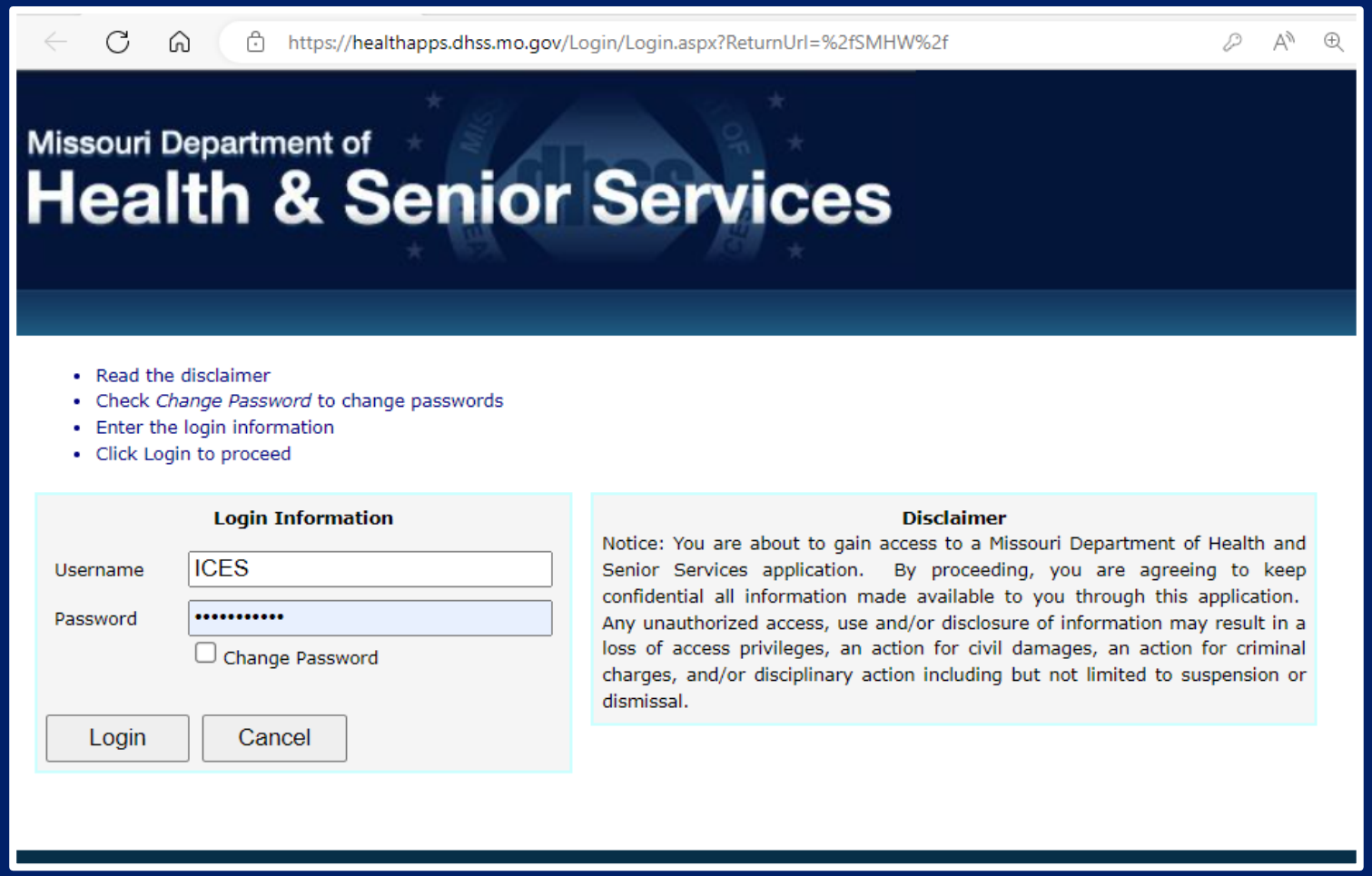
- **The SMHW grant year (FY 25) closed June 29, 2025**

FORM ENTRY INTO MOHSAIC

- MOHSAIC is an online data system used to collect and manage client service records for SMHW and WISEWOMAN. To apply, applicants must submit a request through the **Missouri Department of Health and Senior Services Automated Security Access Process (A.S.A.P)**

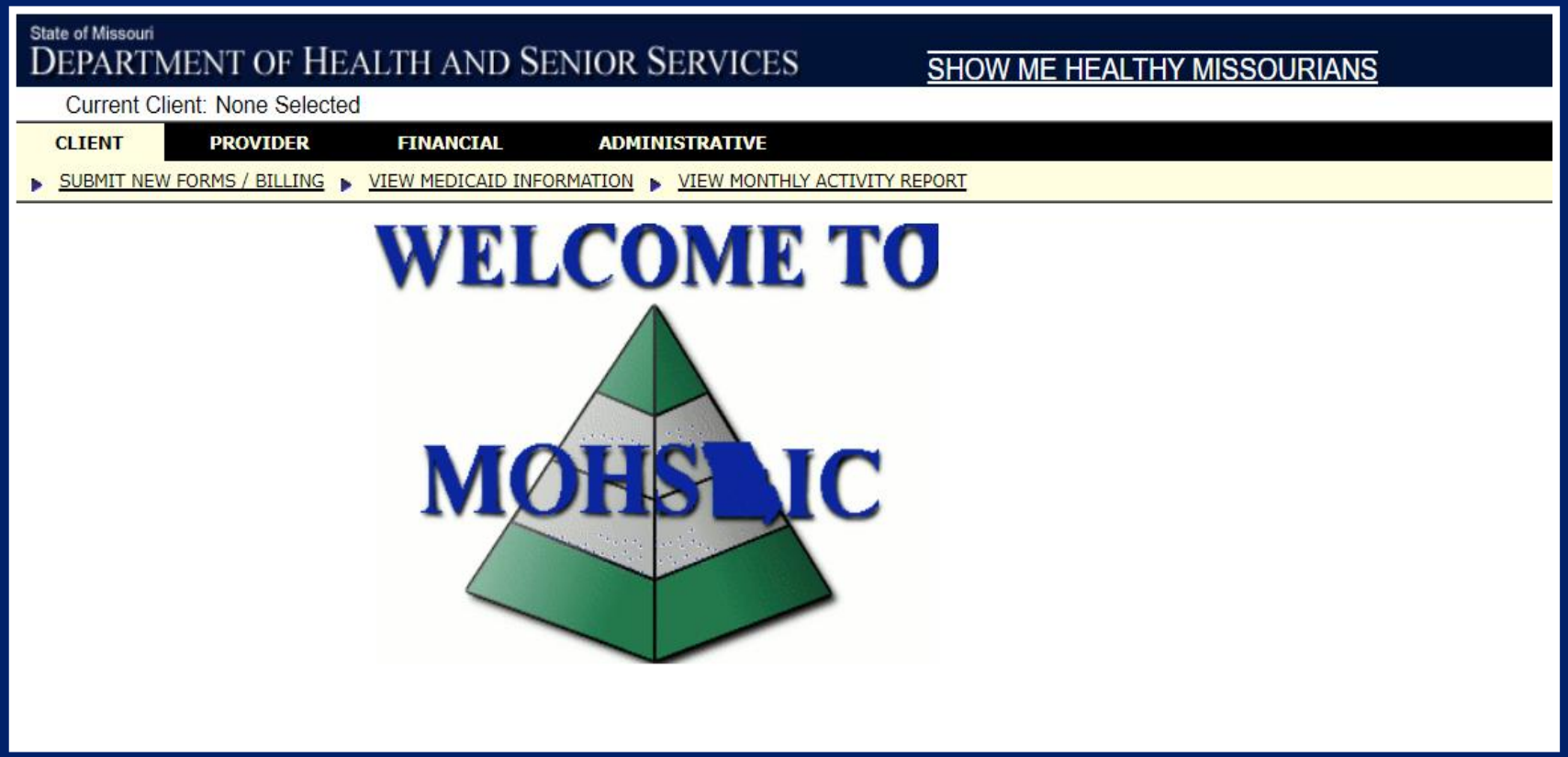
- After receiving authorization with A.S.A.P. and a user log-in, go to https://healthapps.dhss.mo.gov/smhw/. Enter MOHSAIC with your log-in and password. The main screen will open. Do not use Internet Explorer, use Google Chrome or Microsoft Edge

FORM ENTRY INTO MOHSAIC



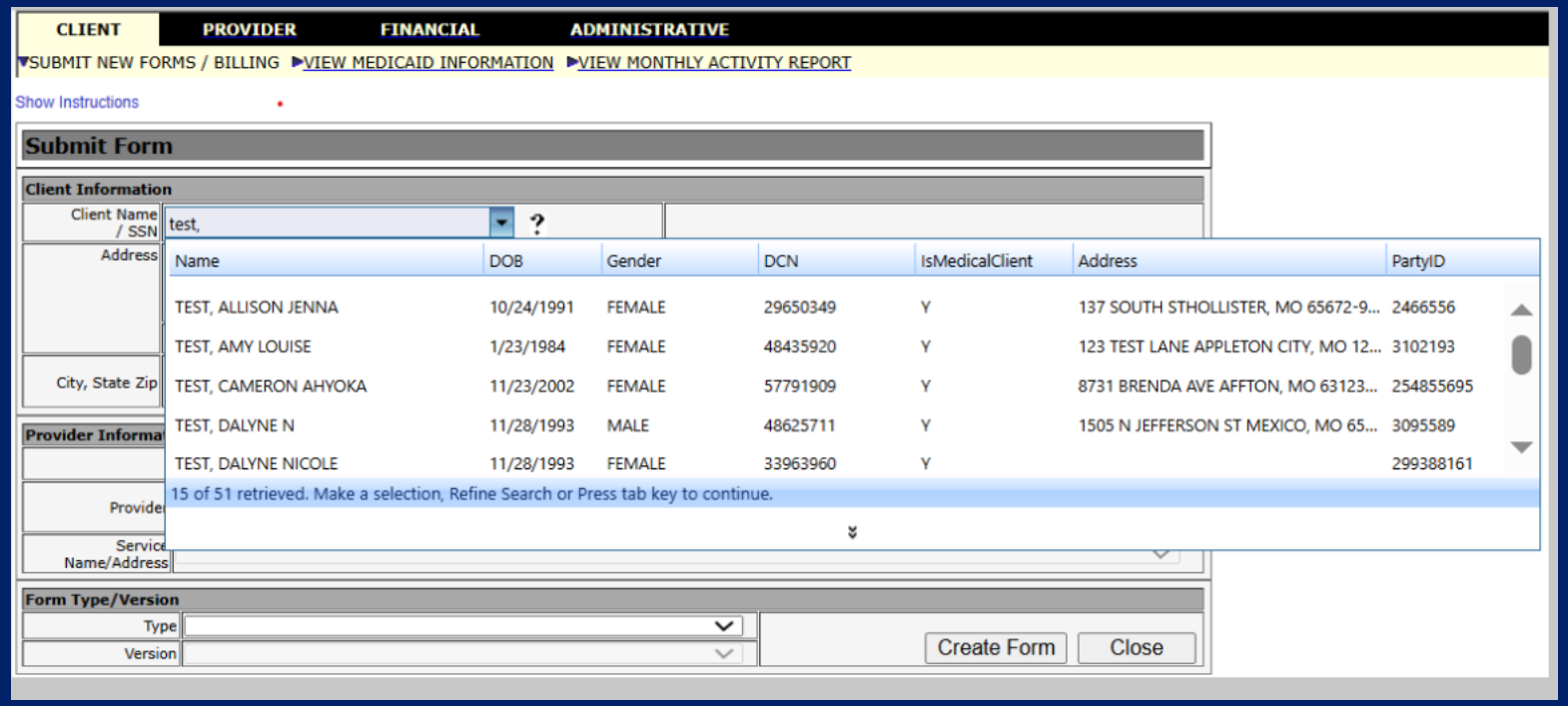
Log-in screen for entry to MOHSAIC

FORM ENTRY INTO MOHSAIC



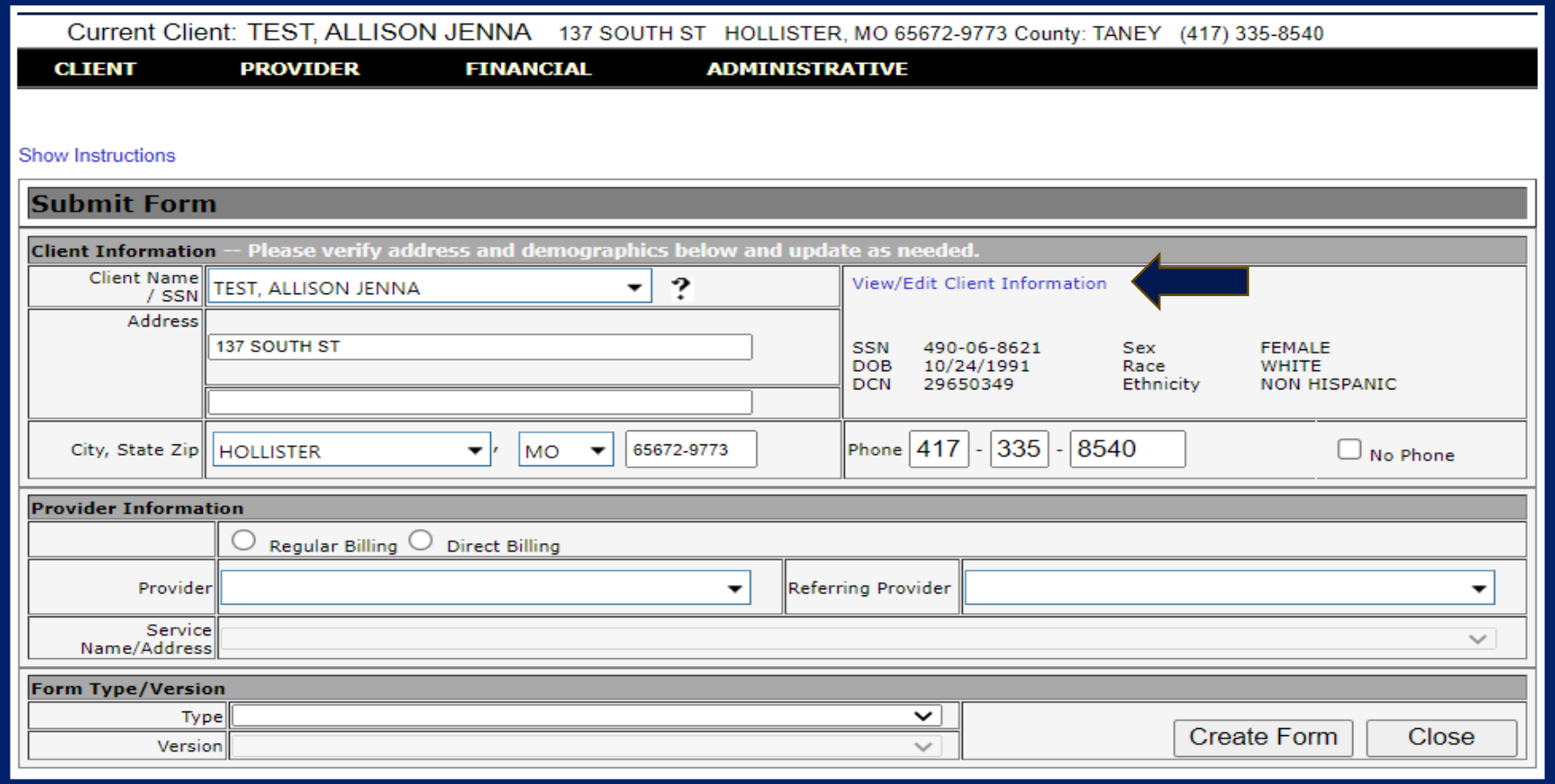
Click the “Client” button. Click “Submit New Forms/Billing”.

FORM ENTRY INTO MOHSAIC



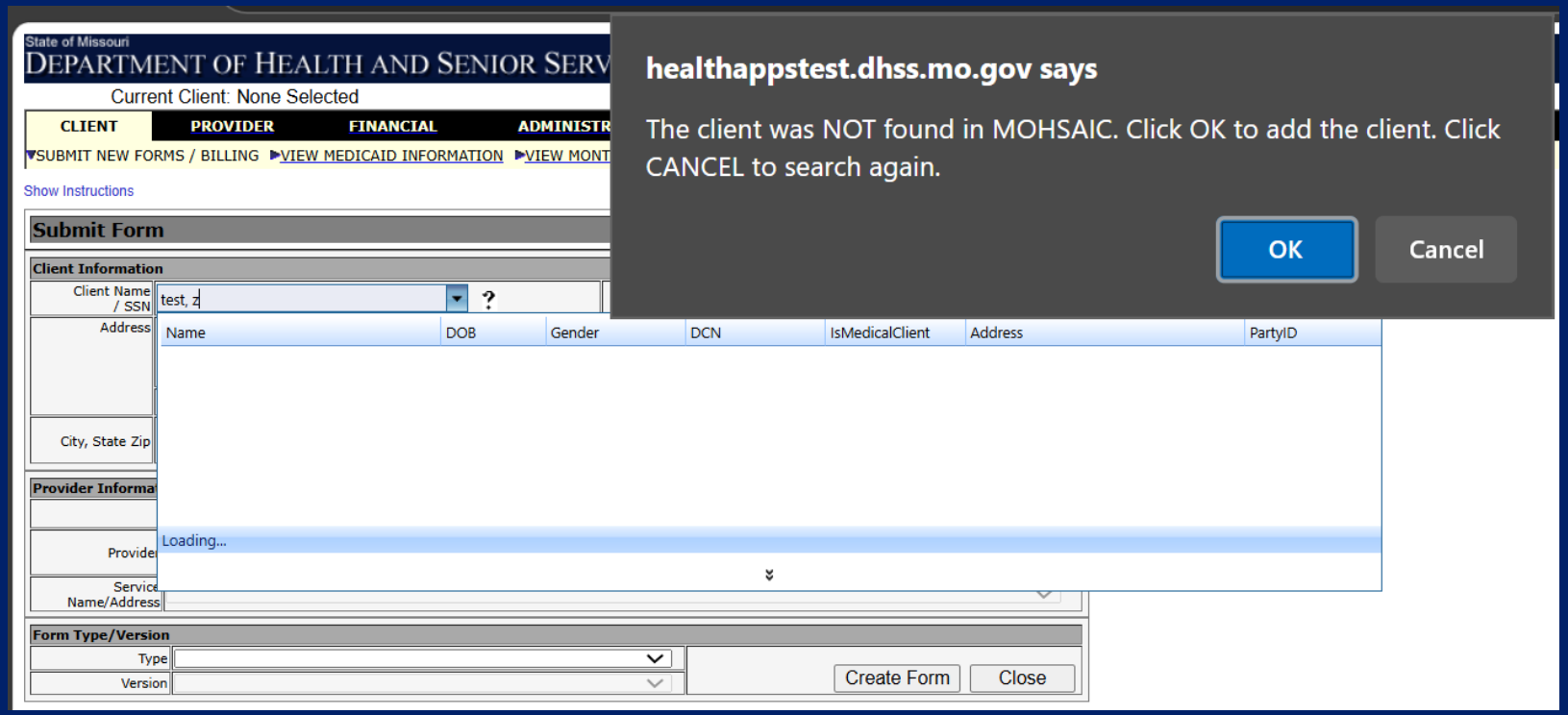
Select the correct patient.
Scroll until you find the correct patient.

FORM ENTRY INTO MOHSAIC



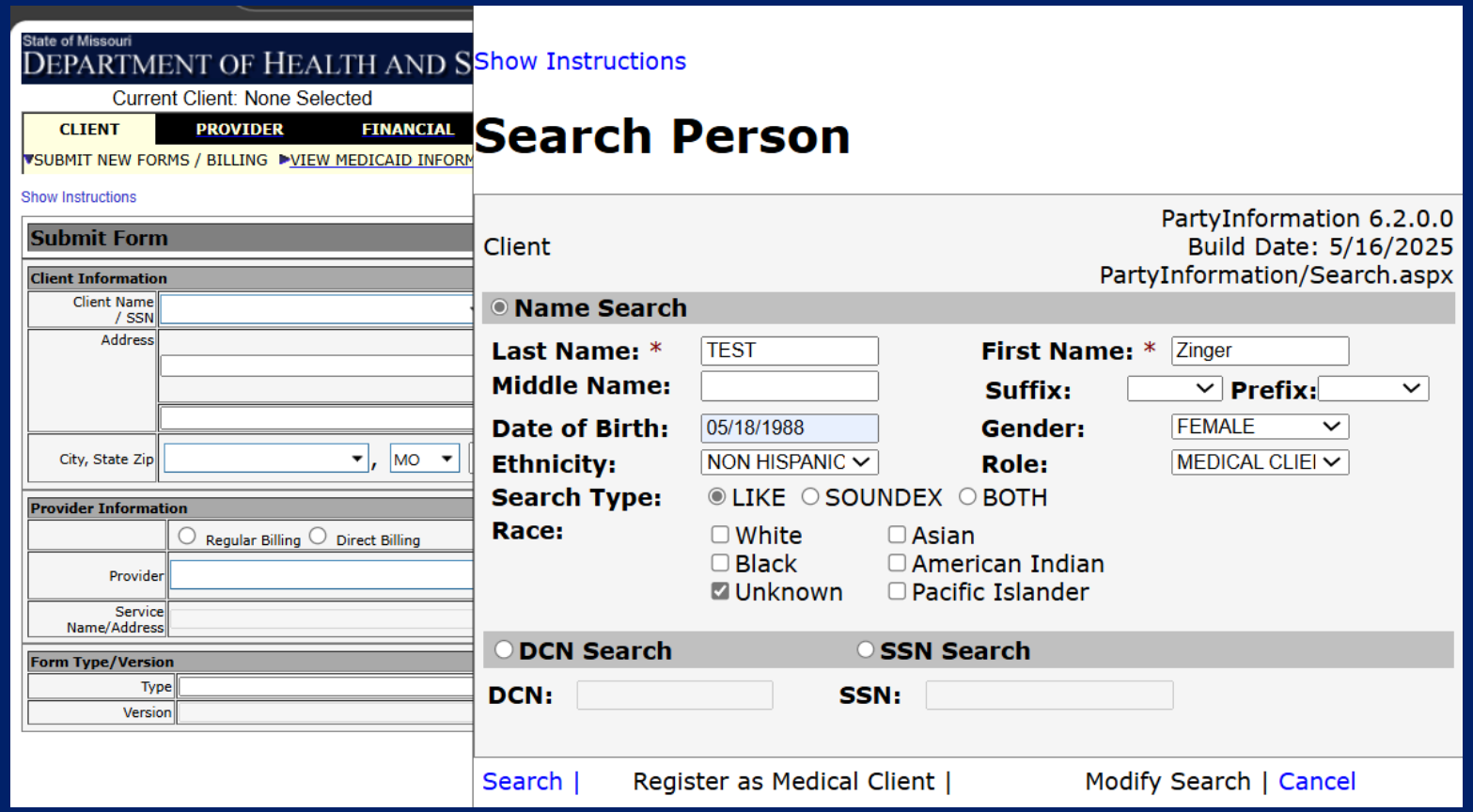
To edit, select "View/Edit Client Information"

FORM ENTRY INTO MOHSAIC



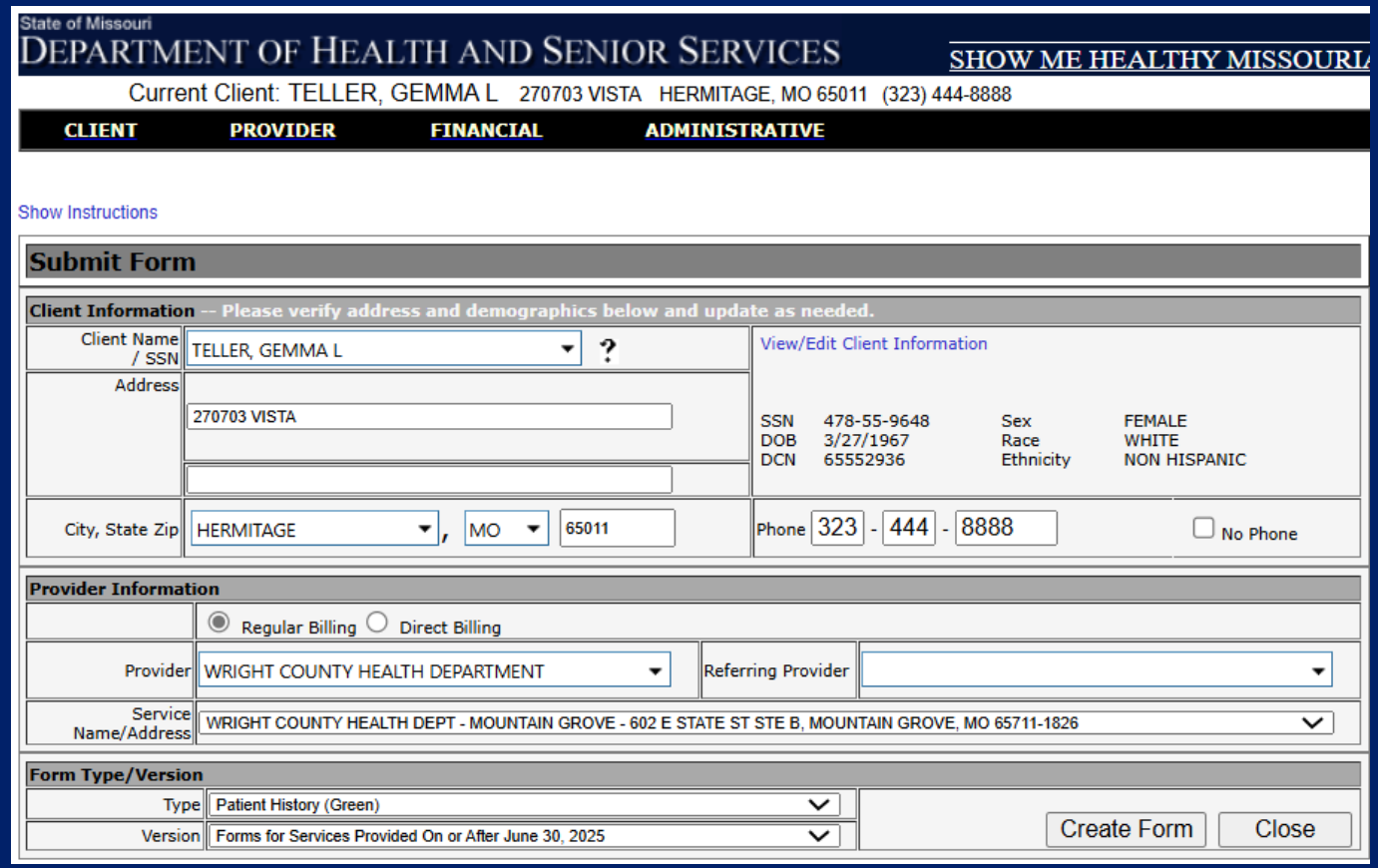
If the client is not in the database, the screen will show the client is not found.

FORM ENTRY INTO MOHSAIC



Enter the patient's information and then select "Register as medical client".

FORM ENTRY INTO MOHSAIC



PROVIDER INFORMATION

SMHW FORMS

History

Screening

Breast Diagnostic

Cervical Diagnostic

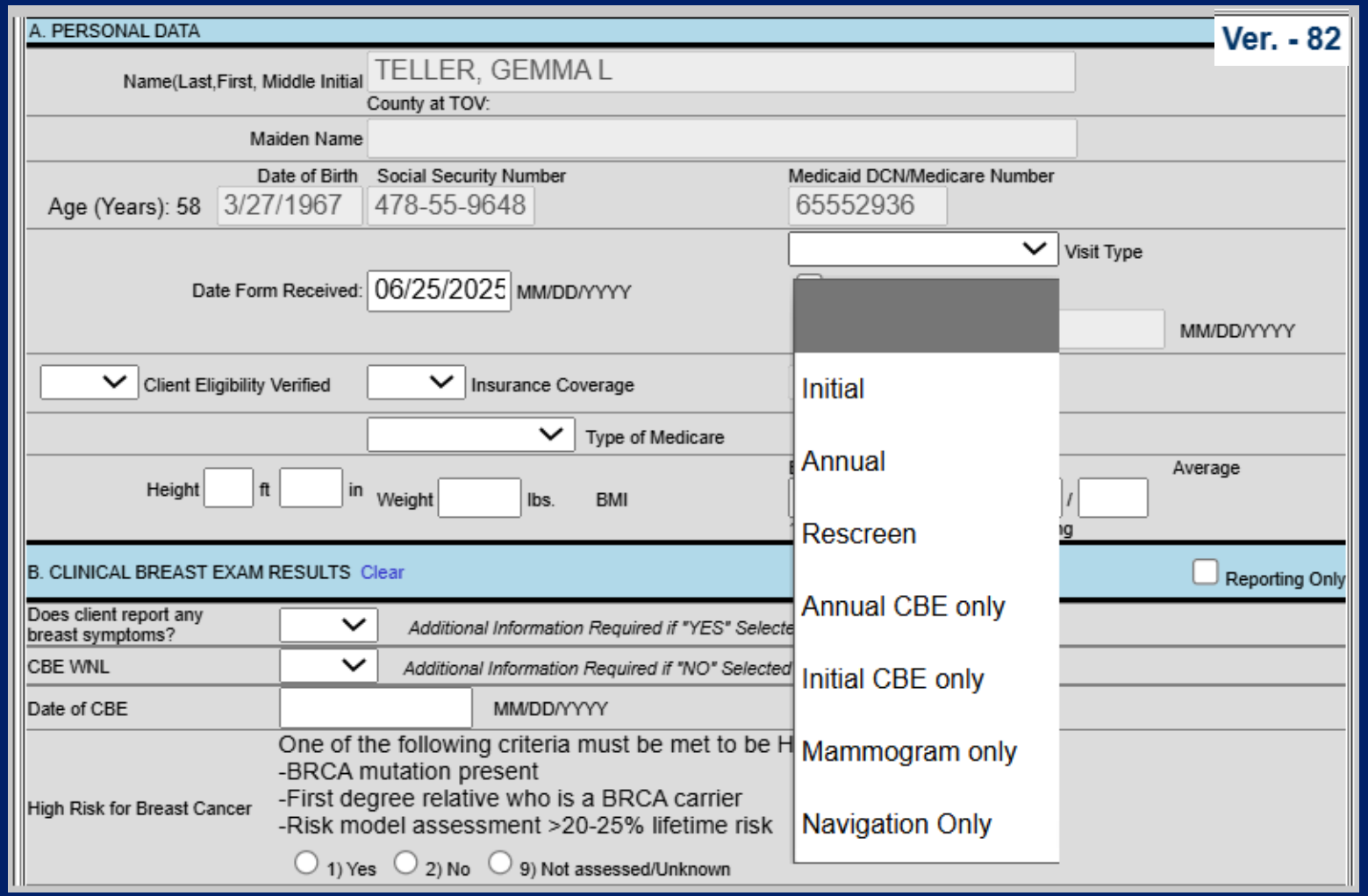
Patient Navigation

Documentation to retain in client's chart:

- Eligibility form
- Proof of age
- Photo ID
- Proof of income
  - Tax form
  - Paycheck stubs

* Each form submission requires attestation confirmation.

SMHW SCREENING REPORT VISIT TYPES



MOHASIC FORM ENTRY

INITIAL

First screening enrollment performed on a woman by a SMHW provider. Or, if a SMHW client has not been seen for 5 years with the same SMHW provider.

ANNUAL

Any future SMHW visits or tests with the SMHW provider.

RESCREEN

A visit can be done with an abnormal result that is less than 10 months from an initial/annual screen date.

Show Me Healthy Women RESCREEN

Use when entering a 6-month follow up diagnostic mammogram or rescreen CBE or cervical abnormalities after benign diagnostics.

A repeat pelvic exam is optional as a rescreen in less than ten (10) months if the previous abnormal pelvic exam reported to SMHW was not within normal limits due to an abnormal **cervical** finding.

If more than 10 months pass from the date of the annual/initial visit, patient must meet SMHW criteria for reimbursement.

TELEHEALTH VISIT

A telehealth visit can be reimbursed when audio **and** video technology is utilized to complete an assessment that includes the client's personal history, family history, risk assessment, benefits and risks of screenings, etc.

Show Me Healthy Women

Mammogram Only – screening mammogram only when a CBE is done elsewhere or the CBE is reported on a separate screening form or a mammogram van visit.

"Navigation-Only" - allows payment for navigation services for women meeting age and income requirements with insurance to pay for screening and diagnostic services.

HIGH RISK ASSESSMENT

During the visit, screen the patient and document their high-risk criteria. If the patient meets the criteria, SMHW may reimburse for a screening breast MRI.

SMHW will reimburse for an annual screening breast MRI as funding is available with **prior written approval.**

Contact your RPC or Central Office to request screening MRI approval. Document the approval in the comment's section of the claim form.

HIGH RISK BREAST

The HIGH-RISK section should be marked YES if the client has:

- ❑ Known genetic mutation such as BRCA 1 or 2
- ❑ First-degree relative who is a BRCA carrier
- ❑ Lifetime risk of 20% or greater as defined by risk assessment models such as BRCAPRO, Tyrer-Cuzick or GAIL Model

HIGH RISK CERVICAL

The HIGH-RISK section should be marked YES if the client has:

- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Had an organ transplant
- ❑ Immunocompromised with another health condition
- ❑ Diethylstilbestrol (DES) exposure in utero

SCREENING MAMMOGRAM

The mammography van should coordinate with primary care services for documentation of the clinical breast exam (CBE) to meet quality care guidelines

If a client presents at the mammography van and has not had a CBE, continue with screening services and refer them for primary care services to obtain a CBE.

Document the patient education regarding the CBE.

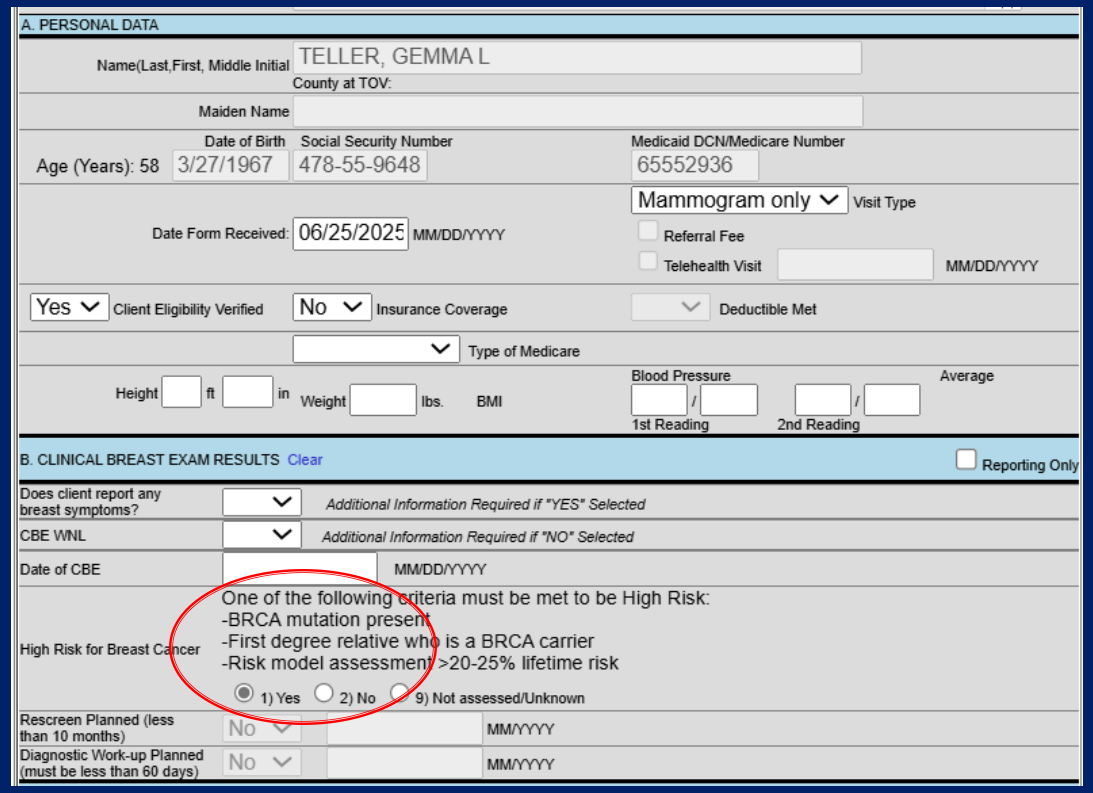
SMHW reimburses the provider for the office visit performing the CBE.

SCREENING MAMMOGRAM

A patient 40 to 64 years old, has an appointment scheduled on a mammogram van. When submitting the reimbursement MOHSAIC claim form, note this as a mammogram van visit. For clinical best practice, a CBE should be completed at a well-woman check-up (annually). Please encourage and document the conversation promoting the patient to receive a CBE with a well-woman check-up appointment. If the patient has completed a CBE, document where the CBE was completed in the comments section of the MOHSAIC reimbursement form.

Show Me Healthy Women

- Select visit type as “Mammogram Only” to bill a *screening mammogram*



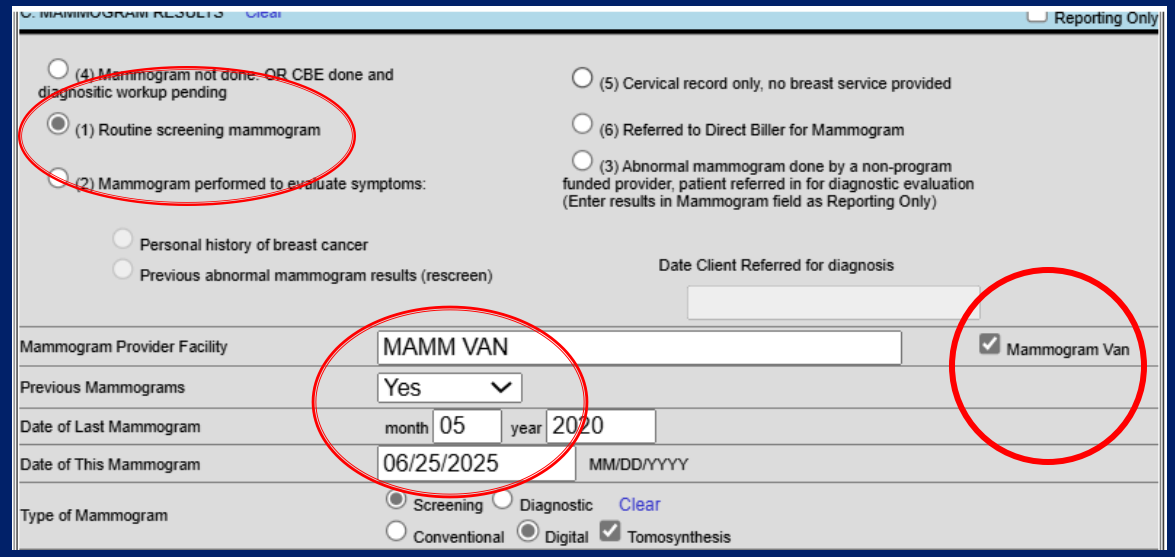
A. PERSONAL DATA

Name(Last,First, Middle Initial: TELLER, GEMMA L
County at TOV:
Maiden Name:
Date of Birth: 3/27/1967 | Social Security Number: 478-55-9648 | Medicaid DCN/Medicare Number: 65552936
Age (Years): 58
Mammogram only — Visit Type
Date Form Received: 06/25/2025 MM/DD/YYYY
Referral Fee
Telehealth Visit MM/DD/YYYY
Yes — Client Eligibility Verified | No — Insurance Coverage | Deductible Met
Type of Medicare
Height ft in | Weight lbs. | BMI | Blood Pressure 1st Reading / 2nd Reading | Average

B. CLINICAL BREAST EXAM RESULTS Clear — Reporting Only

Does client report any breast symptoms? — *Additional Information Required if "YES" Selected*
CBE WNL — *Additional Information Required if "NO" Selected*
Date of CBE MM/DD/YYYY
High Risk for Breast Cancer
One of the following criteria must be met to be High Risk:
-BRCA mutation present
-First degree relative who is a BRCA carrier
-Risk model assessment >20-25% lifetime risk
1) Yes 2) No 9) Not assessed/Unknown
Rescreen Planned (less than 10 months) — No — MM/YYYY
Diagnostic Work-up Planned (must be less than 60 days) — No — MM/YYYY

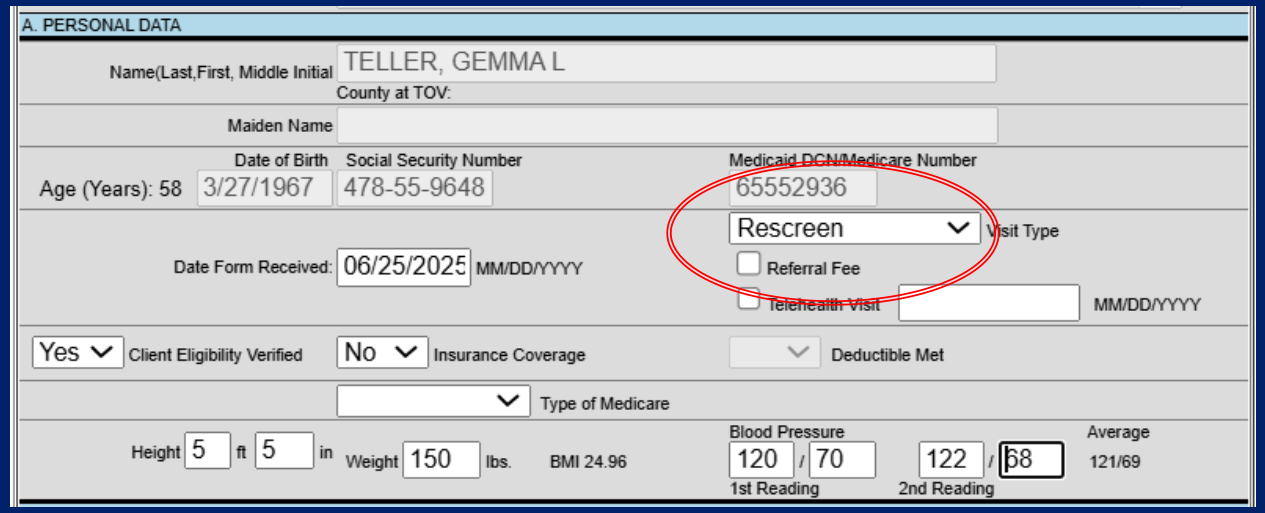
Show Me Healthy Women



MAMMOGRAM DIAGNOSTIC RESCREEN

RESCREENING NOTE:

Use when entering a 6-month follow up diagnostic mammogram or rescreen CBE or cervical abnormalities after benign diagnostics.

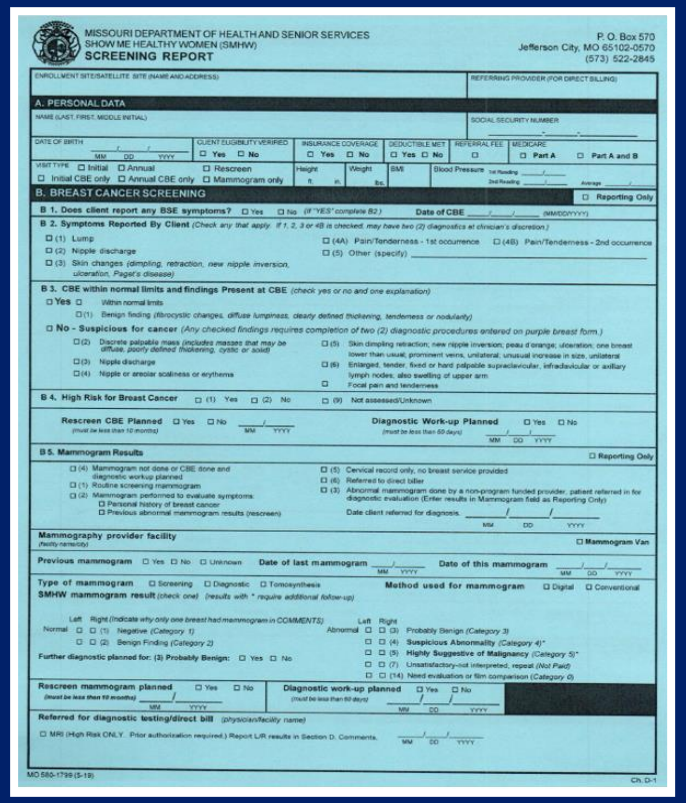

A. PERSONAL DATA

Name(Last,First, Middle Initial: TELLER, GEMMA L
County at TOV:
Maiden Name:
Date of Birth: 3/27/1967
Social Security Number: 478-55-9648
Medicaid DCN/Medicare Number: 65552936
Age (Years): 58
Visit Type: Rescreen
Date Form Received: 06/25/2025 MM/DD/YYYY
Referral Fee
Telehealth Visit MM/DD/YYYY
Yes Client Eligibility Verified
No Insurance Coverage
Deductible Met
Type of Medicare
Height 5 ft 5 in
Weight 150 lbs.
BMI 24.96
Blood Pressure
1st Reading: 120 / 70
2nd Reading: 122 / 68
Average: 121/69

MOHASIC Screening Form

Show Me Healthy Women

Use for a screening mammogram with normal SBE/CBE findings
Use for the entry of a 6-month diagnostic mammogram rescreen



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)
SCREENING REPORT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE SITE (NAME AND ADDRESS) | REFERRING PROVIDER (FOR DIRECT BILLING)

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL) | SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM DD YYYY) | CLIENT ELIGIBILITY VERIFIED ☐ Yes ☐ No | INSURANCE COVERAGE ☐ Yes ☐ No | DEDUCTIBLE MET ☐ Yes ☐ No | REFERRAL FEE ☐ | MEDICARE ☐ Part A ☐ Part A and B

VISIT TYPE ☐ Initial ☐ Annual ☐ Rescreen ☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only | Height ft. in. | Weight lbs. | BMI | Blood Pressure 1st Reading ___/___ 2nd Reading ___/___ Average ___/___

B. BREAST CANCER SCREENING ☐ Reporting Only

B 1. Does client report any BSE symptoms? ☐ Yes ☐ No *(If "YES" complete B2.)* **Date of CBE** ___/___/___ (MM/DD/YYYY)

B 2. Symptoms Reported By Client *(Check any that apply. If 1, 2, 3 or 4B is checked, may have two (2) diagnostics at clinician's discretion.)*

☐ (1) Lump
☐ (2) Nipple discharge
☐ (3) Skin changes *(dimpling, retraction, new nipple inversion, ulceration, Paget's disease)*
☐ (4A) Pain/Tenderness - 1st occurrence ☐ (4B) Pain/Tenderness - 2nd occurrence
☐ (5) Other (specify) ___

B 3. CBE within normal limits and findings Present at CBE *(check yes or no and one explanation)*

☐ **Yes** ☐ Within normal limits
☐ (1) Benign finding *(fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)*

☐ **No - Suspicious for cancer** *(Any checked findings requires completion of two (2) diagnostic procedures entered on purple breast form.)*
☐ (2) Discrete palpable mass *(includes masses that may be diffuse, poorly defined thickening, cystic or solid)*
☐ (3) Nipple discharge
☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling retraction; new nipple inversion; peau d'orange; ulceration; one breast lower than usual; prominent veins, unilateral, unusual increase in size, unilateral
☐ (6) Enlarged, tender, fixed or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm
☐ Focal pain and tenderness

B 4. High Risk for Breast Cancer ☐ (1) Yes ☐ (2) No ☐ (9) Not assessed/Unknown

Rescreen CBE Planned ☐ Yes ☐ No ___/___ *(must be less than 10 months)* | **Diagnostic Work-up Planned** ☐ Yes ☐ No ___/___/___ *(must be less than 60 days)*

B 5. Mammogram Results ☐ Reporting Only

☐ (4) Mammogram not done or CBE done and diagnostic workup planned
☐ (1) Routine screening mammogram
☐ (2) Mammogram performed to evaluate symptoms:
☐ Personal history of breast cancer
☐ Previous abnormal mammogram results (rescreen)
☐ (5) Cervical record only, no breast service provided
☐ (6) Referred to direct biller
☐ (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date client referred for diagnosis. ___/___/___

Mammography provider facility *(facility name/city)* ☐ Mammogram Van

Previous mammogram ☐ Yes ☐ No ☐ Unknown **Date of last mammogram** ___/___ **Date of this mammogram** ___/___/___

Type of mammogram ☐ Screening ☐ Diagnostic ☐ Tomosynthesis **Method used for mammogram** ☐ Digital ☐ Conventional

SMHW mammogram result *(check one) (results with * require additional follow-up)*

Left Right *(Indicate why only one breast had mammogram in COMMENTS)*
Normal ☐ ☐ (1) Negative *(Category 1)*
☐ ☐ (2) Benign Finding *(Category 2)*
Abnormal ☐ ☐ (3) Probably Benign *(Category 3)*
☐ ☐ (4) **Suspicious Abnormality** *(Category 4)**
☐ ☐ (5) **Highly Suggestive of Malignancy** *(Category 5)**
☐ ☐ (7) Unsatisfactory-not interpreted, repeat *(Not Paid)*
☐ ☐ (14) Need evaluation or film comparison *(Category 0)*

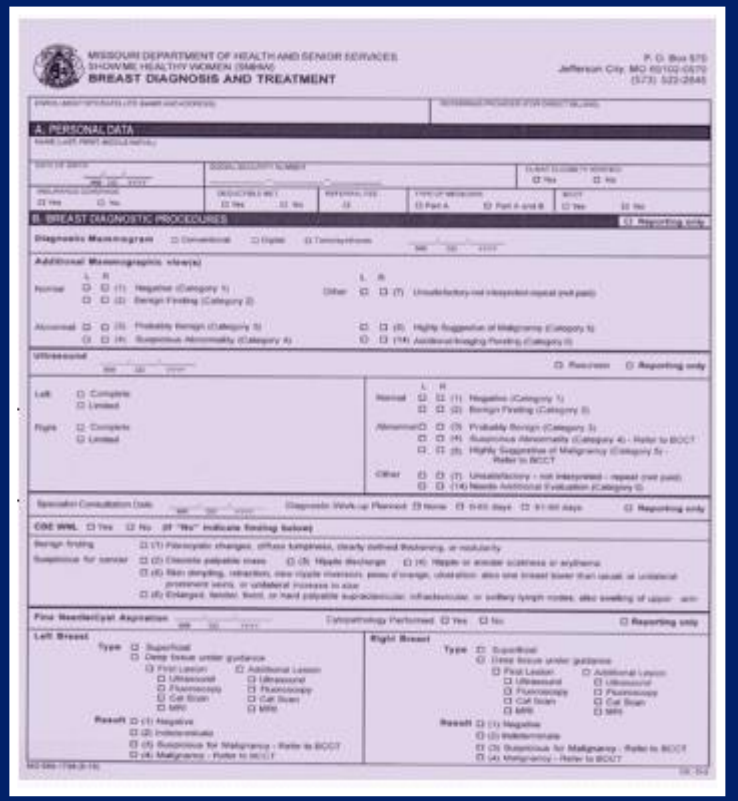
Further diagnostic planned for: (3) Probably Benign: ☐ Yes ☐ No

Rescreen mammogram planned ☐ Yes ☐ No ___/___ *(must be less than 10 months)* | **Diagnostic work-up planned** ☐ Yes ☐ No ___/___/___ *(must be less than 60 days)*

Referred for diagnostic testing/direct bill *(physician/facility name)*
☐ MRI (High Risk ONLY. Prior authorization required.) Report L/R results in Section D, Comments. ___/___/___

MO 580-1799 (5-19) Ch. D-1

Use for entry of diagnostic mammogram with abnormal SBE/CBE findings



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)
BREAST DIAGNOSIS AND TREATMENT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

A. PERSONAL DATA

B. BREAST DIAGNOSTIC PROCEDURES ☐ Reporting only

Diagnostic Mammogram ☐ Conventional ☐ Digital ☐ Tomosynthesis

Additional Mammographic view(s)

L R
Normal ☐ ☐ (1) Negative (Category 1)
☐ ☐ (2) Benign Finding (Category 2)
Abnormal ☐ ☐ (3) Probably Benign (Category 3)
☐ ☐ (4) Suspicious Abnormality (Category 4) - Refer to BCCT
☐ ☐ (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT
Other ☐ ☐ (7) Unsatisfactory - not interpreted - repeat (not paid)
☐ ☐ (14) Needs Additional Evaluation (Category 0)

Ultrasound ___/___/___ ☐ Rescreen ☐ Reporting only

Left ☐ Complete ☐ Limited
Right ☐ Complete ☐ Limited

L R
Normal ☐ ☐ (1) Negative (Category 1)
☐ ☐ (2) Benign Finding (Category 2)
Abnormal ☐ ☐ (3) Probably Benign (Category 3)
☐ ☐ (4) Suspicious Abnormality (Category 4) - Refer to BCCT
☐ ☐ (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT
Other ☐ ☐ (7) Unsatisfactory - not interpreted - repeat (not paid)
☐ ☐ (14) Needs Additional Evaluation (Category 0)

Specialist Consultation (date) ___/___/___ Diagnostic Work-up Planned ☐ None ☐ 0-60 days ☐ 61-90 days ☐ Reporting only

CBE WNL ☐ Yes ☐ No *(If "No" indicate finding below)*

Benign finding ☐ (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity
Suspicious for cancer ☐ (2) Discrete palpable mass ☐ (3) Nipple discharge ☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; or unilateral prominent veins, or unilateral increase in size
☐ (6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm

Fine Needle/Cyst Aspiration ___/___/___ Cytopathology Performed ☐ Yes ☐ No ☐ Reporting only

Left Breast
Type ☐ Superficial ☐ Deep tissue under guidance
☐ First Lesion ☐ Additional Lesion
☐ Ultrasound ☐ Ultrasound
☐ Fluoroscopy ☐ Fluoroscopy
☐ Cat Scan ☐ Cat Scan
☐ MRI ☐ MRI
Result ☐ (1) Negative
☐ (2) Indeterminate
☐ (5) Suspicious for Malignancy - Refer to BCCT
☐ (4) Malignancy - Refer to BCCT

Right Breast
Type ☐ Superficial ☐ Deep tissue under guidance
☐ First Lesion ☐ Additional Lesion
☐ Ultrasound ☐ Ultrasound
☐ Fluoroscopy ☐ Fluoroscopy
☐ Cat Scan ☐ Cat Scan
☐ MRI ☐ MRI
Result ☐ (1) Negative
☐ (2) Indeterminate
☐ (5) Suspicious for Malignancy - Refer to BCCT
☐ (4) Malignancy - Refer to BCCT

BREAST AND CERVICAL CANCER TREATMENT ACT (BCCT)

- Client is enrolled in SMHW **prior** to tissue biopsy **and** has a screening or diagnostic test paid by SMHW

- Please note: If the only service reimbursed by SMHW is a referral fee, the client **will not** be eligible for BCCT

BCCT

- Diagnosed with breast and/or cervical cancer, or cervical precancerous condition through a SMHW provider
- No source of health/medical insurance that covers treatment (even if a high deductible/Affordable Care Act)
- Meet SMHW eligibility guidelines
- Need treatment for breast and/or cervical cancers or precancerous conditions

Show Me Healthy Women

- ❑ **Ultrasound** of "suspicious abnormality"(**BI-RADS category 4**)** or "highly suggestive of malignancy"
- ❑ (**BI-RADS category 5**)**
- ❑ Carcinoma in situ*
- ❑ Invasive breast cancer*
- ❑ CIN 2/moderate dysplasia*
- ❑ CIN 3/severe dysplasia *
- ❑ CIS or AIS *
- ❑ Invasive cervical cancer *

*ELIGIBLE FOR FULL BCCT
**ELIGIBLE FOR PRESUMPTIVE BCCT
A presumptive BCCT application SHOULD always be submitted first

AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY (ASCCP) GUIDELINES

- The American Society for Colposcopy and Cervical Pathology (ASCCP) user friendly app for guidelines for managing abnormal cervical cancer screening test. Guidelines and algorithms can be viewed at https://www.asccp.org.

- The mobile application is located at https://www.asccp.org/mobile-app.

ASCCP GUIDELINES

SMHW will reimburse for clinician collected cervical HPV specimens, or in-office, self-collected vaginal HPV specimens.

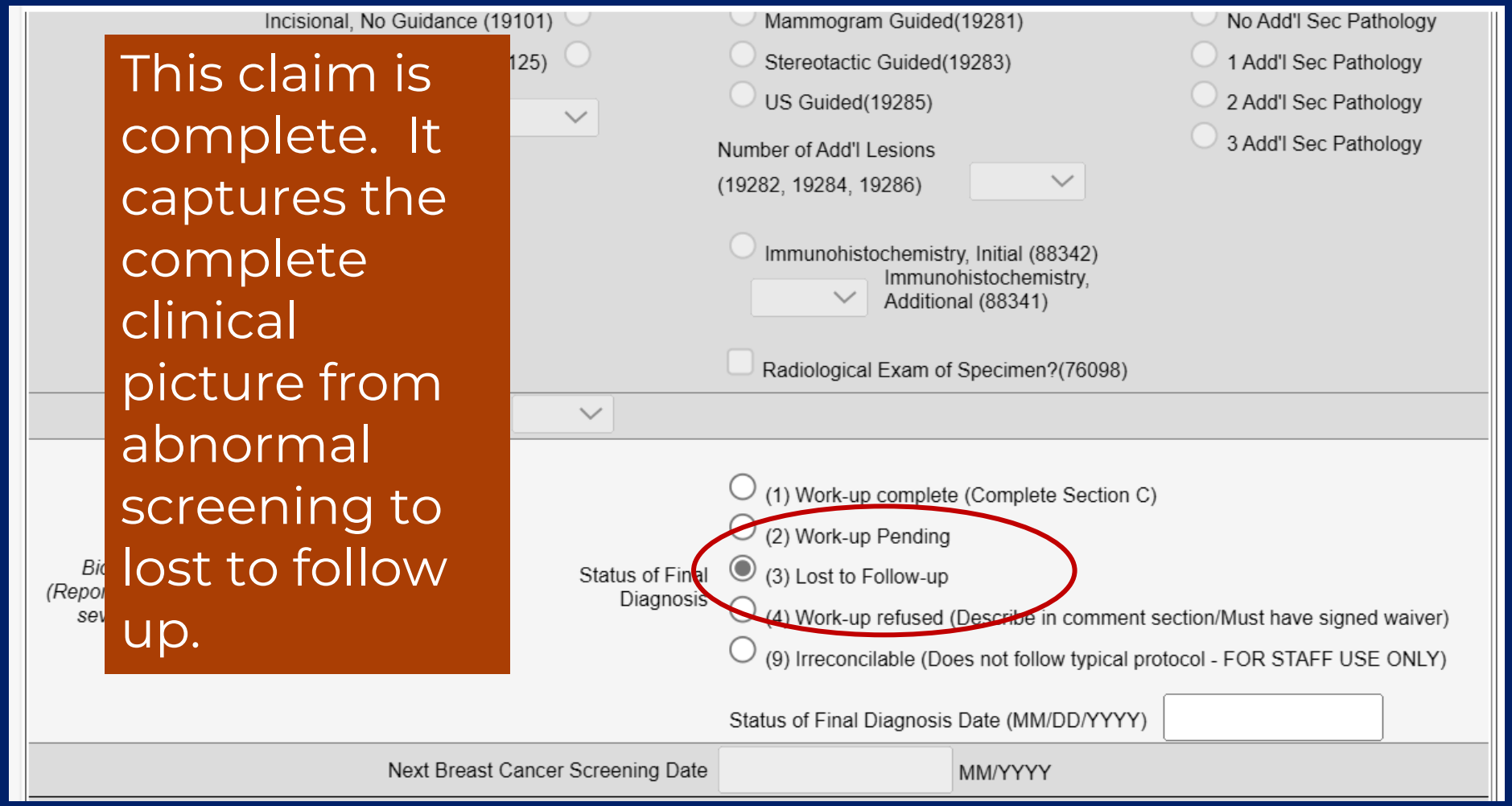
Vaginal test kits must be BD Onclarity or Roche Cobas.

HPV DNA testing is a reimbursable procedure if used in conjunction with pap testing or for follow-up of an abnormal pap result or surveillance per ASCCP guidelines.

LOST TO FOLLOW UP PROCESS

- ❑ All abnormal breast or cervical results
- ❑ Notify and explain the need for additional diagnostic service(s).
- ❑ SMHW requires **two documented** attempts for client follow-up
- ❑ If unable to reach client, a letter should be sent. For legal purposes, providers are encouraged to use a certified letter.
- ❑ If no response is received or the client refuses further diagnostics and/or treatments, notify your RPC. SMHW will send a certified letter.

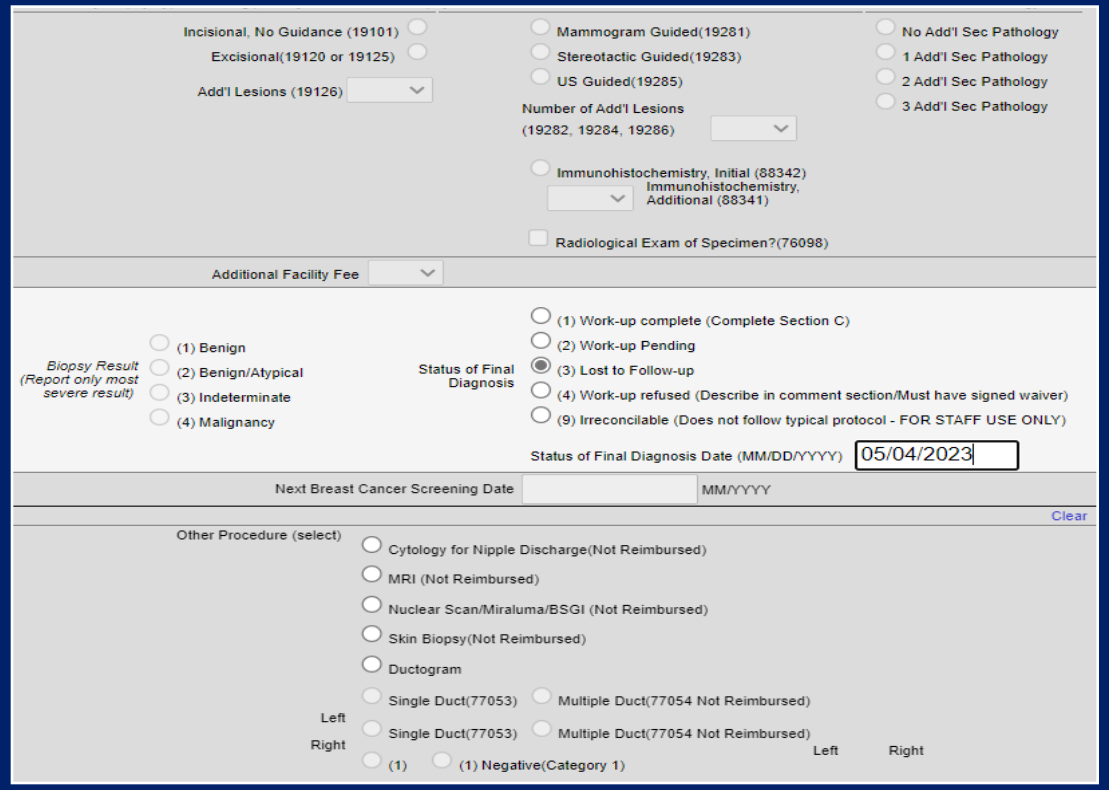
EXAMPLE OF LOST TO FOLLOW UP



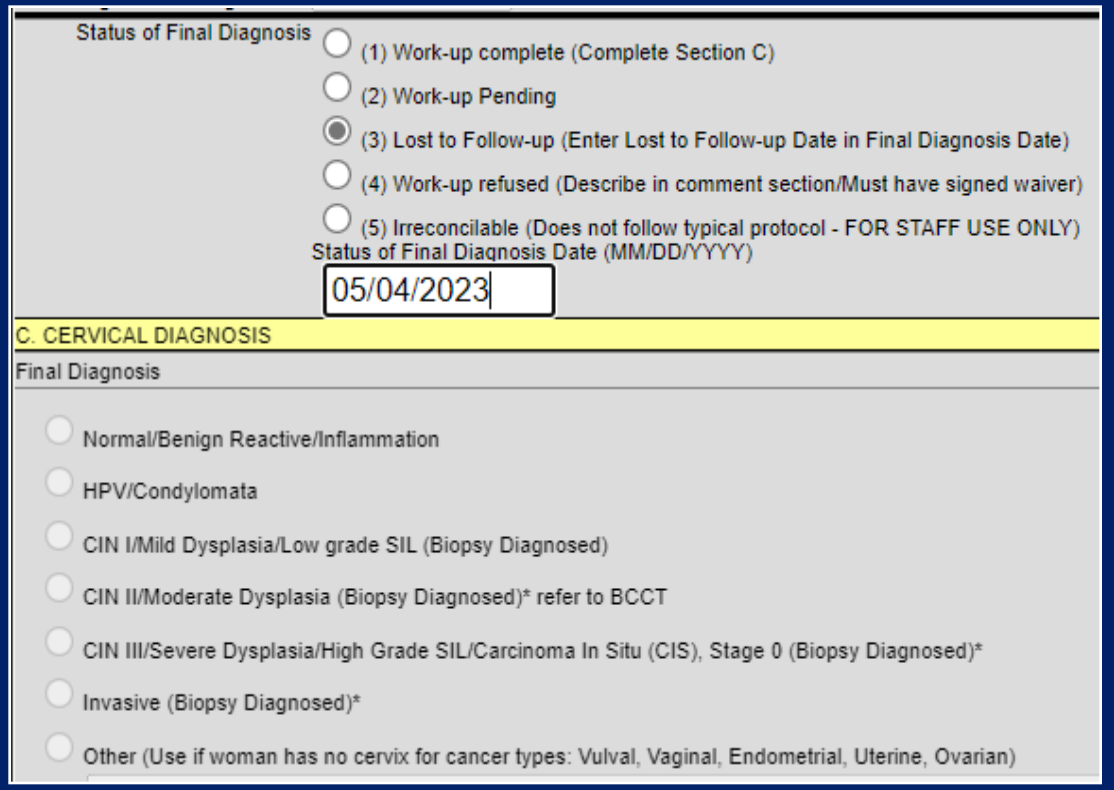
This claim is complete. It captures the complete clinical picture from abnormal screening to lost to follow up.

EXAMPLE OF LOST TO FOLLOW UP

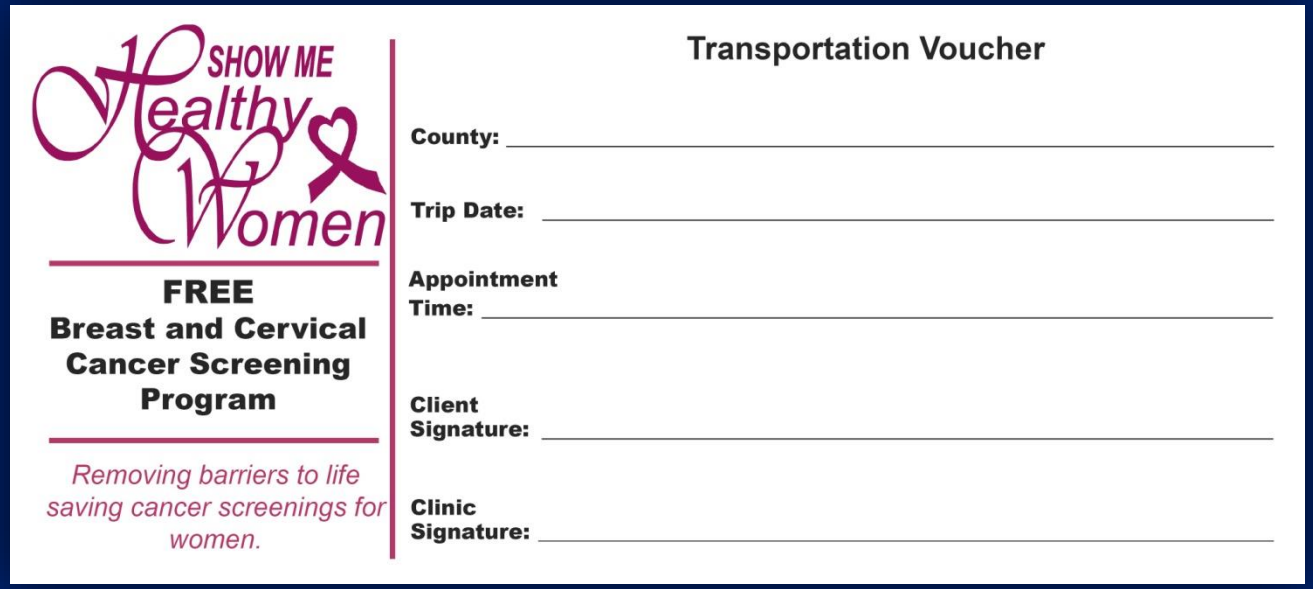
Diagnostic Breast



Diagnostic Cervical



TRANSPORTATION



SHOW ME Healthy Women

FREE
Breast and Cervical Cancer Screening Program

Removing barriers to life saving cancer screenings for women.

Transportation Voucher

County: _____

Trip Date: _____

Appointment Time: _____

Client Signature: _____

Clinic Signature: _____

TRANSPORTATION (CONTINUED)

- SMHW/WISEWOMAN services qualify for free transportation services, including initial office visits, lab visits, follow-up diagnostic office visits, lifestyle education sessions, and annual evaluation screenings.

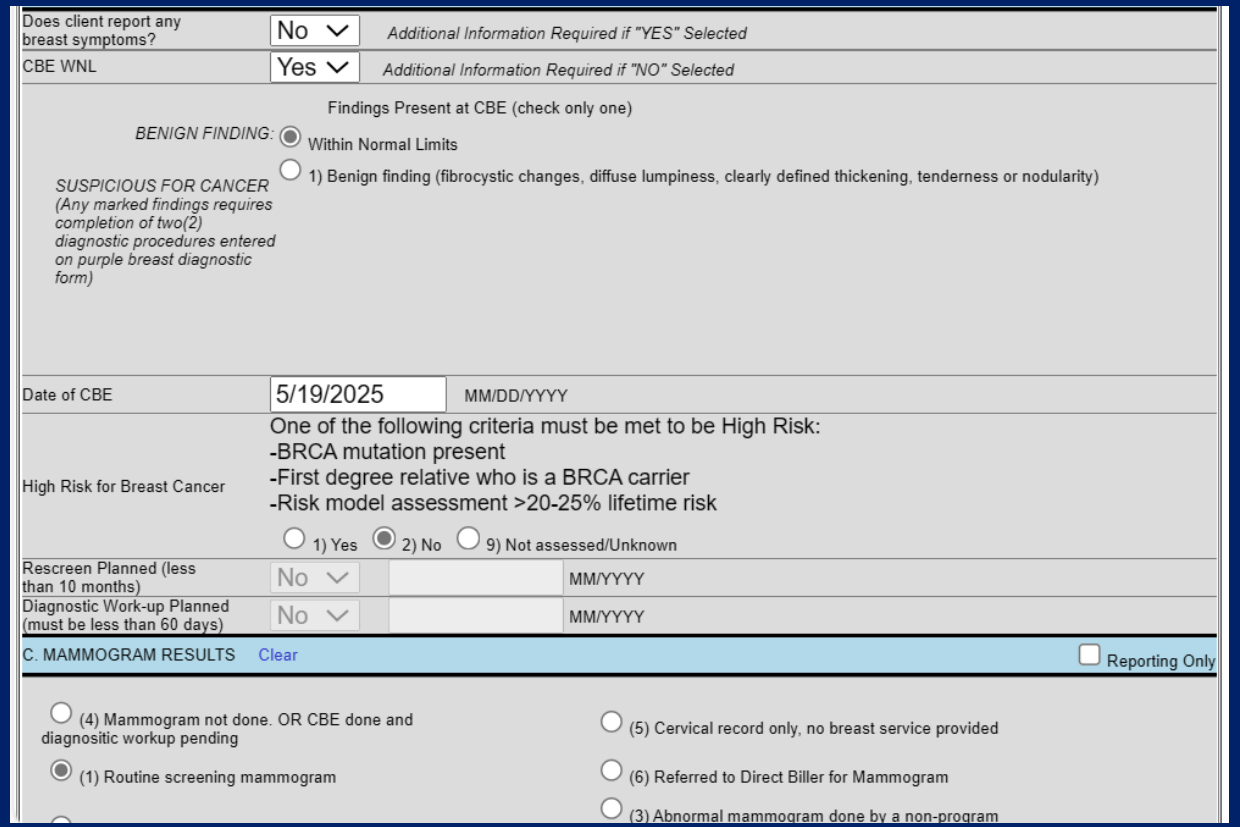
- Contact SMHW staff for travel vouchers or questions regarding transportation arrangements.

REQUEST FROM SMHW FOR ADDITIONAL INFORMATION

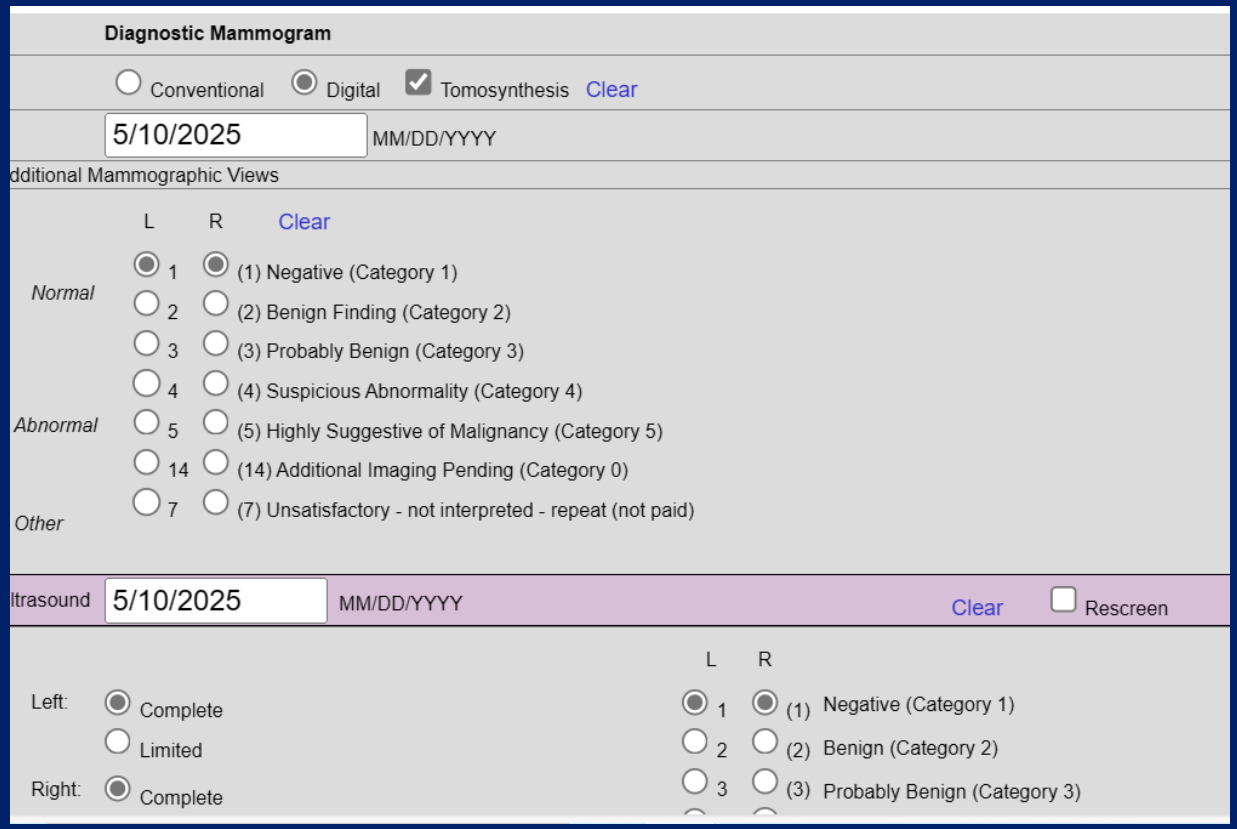
- ❑ Normal screening with a diagnostic form
- ❑ Incomplete form
- ❑ Missing a lost to follow up form

NORMAL SCREENING WITH ABNORMAL

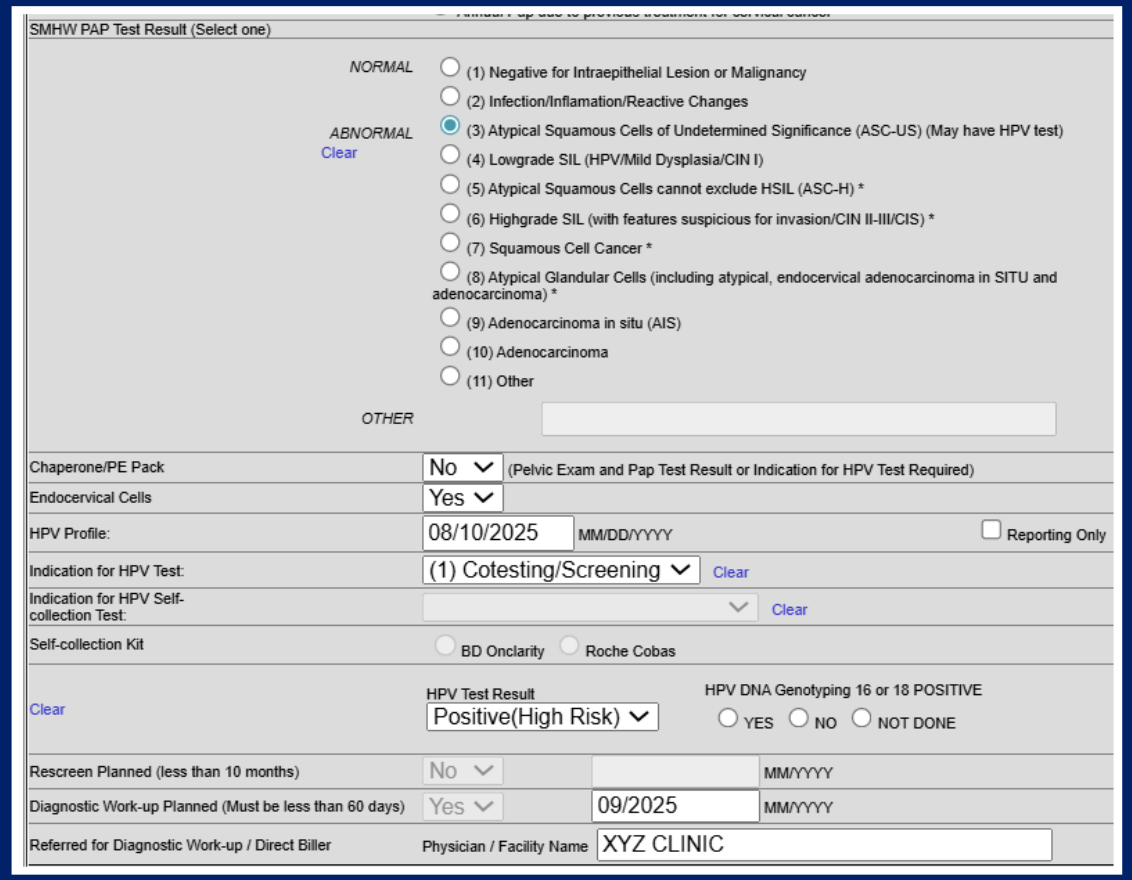
Normal Screening



Diagnostic Breast



INCOMPLETE FORM EXAMPLE


SMHW PAP Test Result (Select one)

NORMAL
(1) Negative for Intraepithelial Lesion or Malignancy
(2) Infection/Inflamation/Reactive Changes

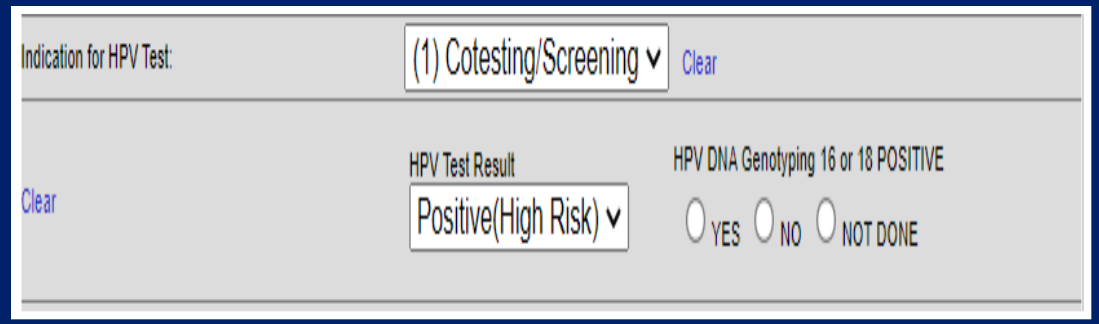
ABNORMAL
Clear
(3) Atypical Squamous Cells of Undetermined Significance (ASC-US) (May have HPV test)
(4) Lowgrade SIL (HPV/Mild Dysplasia/CIN I)
(5) Atypical Squamous Cells cannot exclude HSIL (ASC-H) *
(6) Highgrade SIL (with features suspicious for invasion/CIN II-III/CIS) *
(7) Squamous Cell Cancer *
(8) Atypical Glandular Cells (including atypical, endocervical adenocarcinoma in SITU and adenocarcinoma) *
(9) Adenocarcinoma in situ (AIS)
(10) Adenocarcinoma
(11) Other

OTHER

Chaperone/PE Pack: No (Pelvic Exam and Pap Test Result or Indication for HPV Test Required)
Endocervical Cells: Yes
HPV Profile: 08/10/2025 MM/DD/YYYY Reporting Only
Indication for HPV Test: (1) Cotesting/Screening Clear
Indication for HPV Self-collection Test: Clear
Self-collection Kit: BD Onclarity Roche Cobas

Clear
HPV Test Result: Positive(High Risk)
HPV DNA Genotyping 16 or 18 POSITIVE: YES NO NOT DONE

Rescreen Planned (less than 10 months): No MM/YYYY
Diagnostic Work-up Planned (Must be less than 60 days): Yes 09/2025 MM/YYYY
Referred for Diagnostic Work-up / Direct Biller: Physician / Facility Name XYZ CLINIC


Indication for HPV Test: (1) Cotesting/Screening Clear

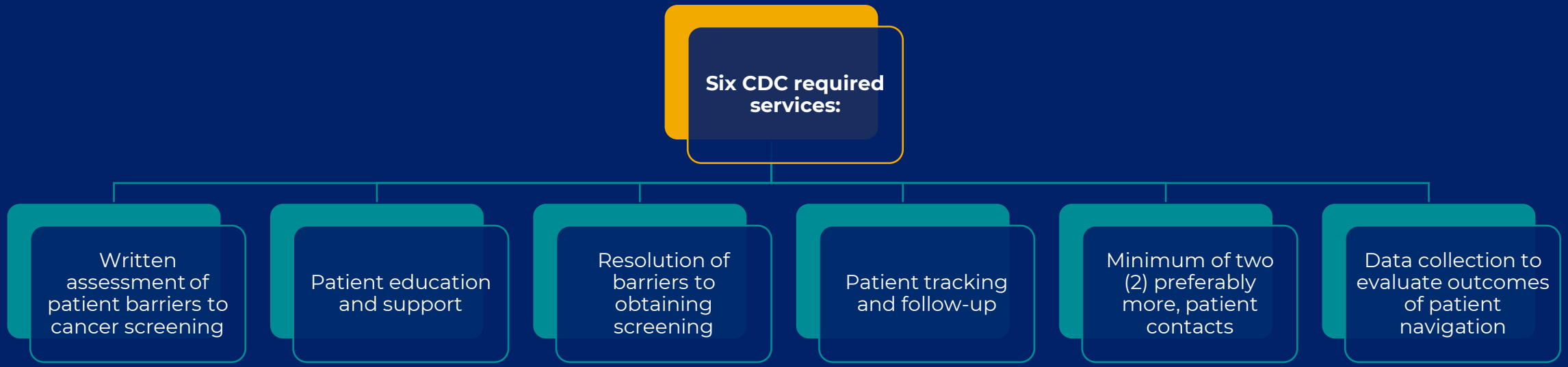
Clear
HPV Test Result: Positive(High Risk)
HPV DNA Genotyping 16 or 18 POSITIVE: YES NO NOT DONE

Complete Yes, No or Not Done

PATIENT NAVIGATION ELIGIBILITY CRITERIA

- Females 21-64 years of age
- Income guidelines at or below 250% of the federal poverty level
- Patient's insured status
- Client with barriers preventing them from obtaining screening services.
- "Navigation-Only" allows payment for navigation services for women meeting age and income requirements with insurance to pay for screening and diagnostic services.

PATIENT NAVIGATION (CONTINUED)



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Show Me Healthy Women

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