



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.

Referred for Diagnostic Work-up / Direct Biller	Physician / Facility Name
I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812. ☐ I Agree	
COMMENTS Maximum length is 1536 characters.	
☐ Override	
Please Be Sure to Mark the "Reporting Only" Box in the Section When Not Requesting Reimbursement	
Submit Cancel	
Select one of the following forms to open after submit (Clear Choice)	

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

Comments

Maximum length is 1536 characters.

INSURANCE PAID:
INSURANCE PAID \$147.91 ON BILATERAL DIAGNOSTIC MAMMO WITH CPT CODE:77066
INSURANCE PAID \$95.43 ON ULTRASOUND WITH CPT CODE: 76641
PAID ZERO ON BREAST BIOPSY WITH CPT CODE: 19100. NANCY NURSE, RN

☐ Override

Please Be Sure to Mark the "Reporting Only" Box in the Section When Not Requesting Reimbursement

Submit

Cancel

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

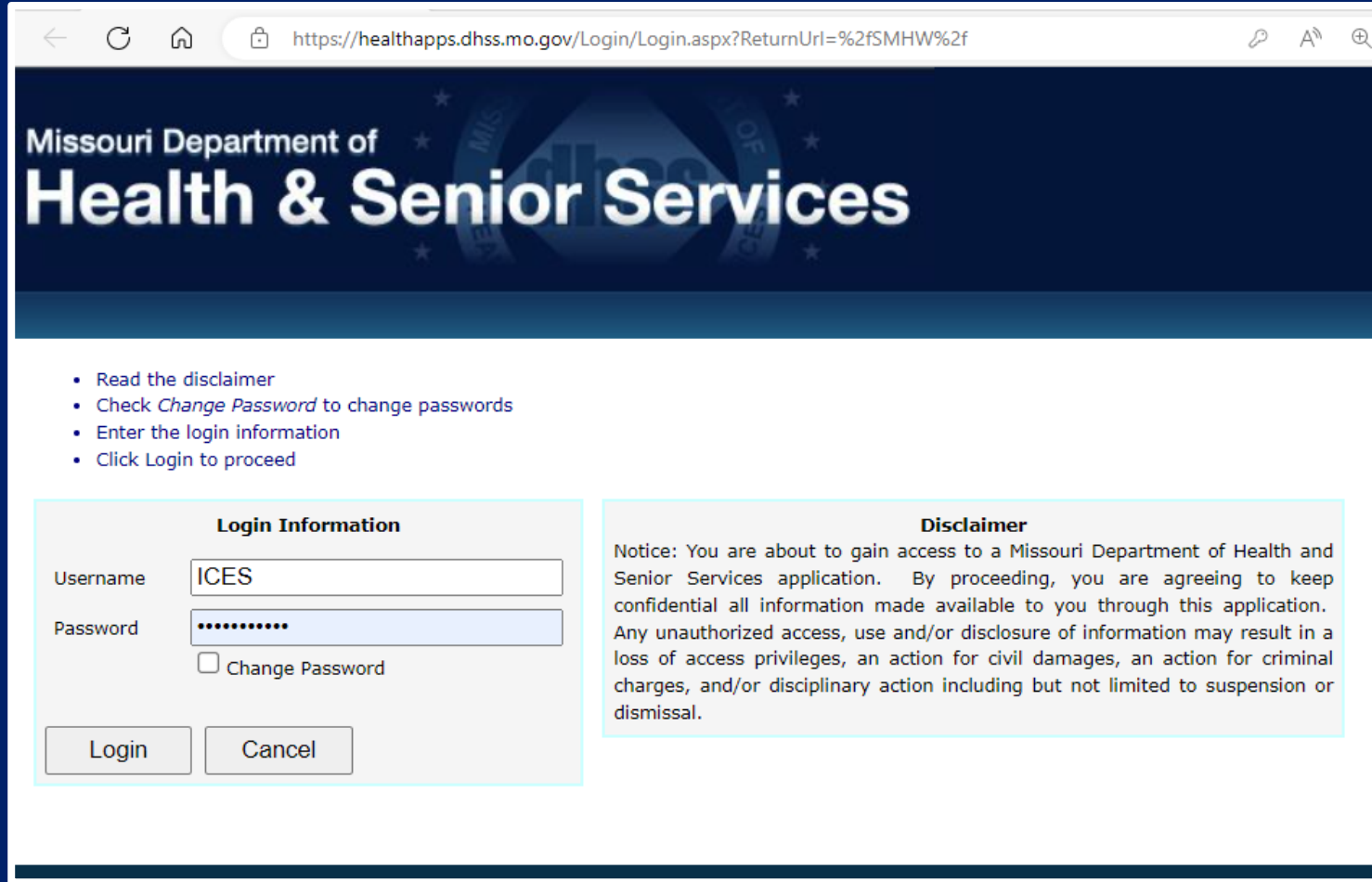
Reminder:

- ❑ **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



Missouri Department of Health & Senior Services

- Read the disclaimer
- Check *Change Password* to change passwords
- Enter the login information
- Click Login to proceed

Login Information

Username: ICES

Password:

☐ Change Password

Login Cancel

Disclaimer

Notice: You are about to gain access to a Missouri Department of Health and Senior Services application. By proceeding, you are agreeing to keep confidential all information made available to you through this application. Any unauthorized access, use and/or disclosure of information may result in a loss of access privileges, an action for civil damages, an action for criminal charges, and/or disciplinary action including but not limited to suspension or dismissal.

Log-in
screen for
entry to
MOHSAIC

FORM ENTRY INTO MOHSAIC

State of Missouri
DEPARTMENT OF HEALTH AND SENIOR SERVICES [SHOW ME HEALTHY MISSOURIANS](#)

Current Client: None Selected

CLIENT	PROVIDER	FINANCIAL	ADMINISTRATIVE
--------	----------	-----------	----------------

▶ [SUBMIT NEW FORMS / BILLING](#) ▶ [VIEW MEDICAID INFORMATION](#) ▶ [VIEW MONTHLY ACTIVITY REPORT](#)

WELCOME TO



MOHSAIC

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

FORM ENTRY INTO MOHSAIC

CLIENT **PROVIDER** **FINANCIAL** **ADMINISTRATIVE**

▼SUBMIT NEW FORMS / BILLING ►VIEW MEDICAID INFORMATION ►VIEW MONTHLY ACTIVITY REPORT

Show Instructions

Submit Form

Client Information

Client Name / SSN: test, ?

Address: Name, DOB, Gender, DCN, IsMedicalClient, Address, PartyID

TEST, ALLISON JENNA	10/24/1991	FEMALE	29650349	Y	137 SOUTH STHOLLISTER, MO 65672-9...	2466556
TEST, AMY LOUISE	1/23/1984	FEMALE	48435920	Y	123 TEST LANE APPLETON CITY, MO 12...	3102193
TEST, CAMERON AHYOKA	11/23/2002	FEMALE	57791909	Y	8731 BRENDA AVE AFFTON, MO 63123...	254855695
TEST, DALYNE N	11/28/1993	MALE	48625711	Y	1505 N JEFFERSON ST MEXICO, MO 65...	3095589
TEST, DALYNE NICOLE	11/28/1993	FEMALE	33963960	Y		299388161

15 of 51 retrieved. Make a selection, Refine Search or Press tab key to continue.

Provider Information

Provider: Service Name/Address

Form Type/Version

Type: Version: Create Form Close

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

FORM ENTRY INTO MOHSAIC

Current Client: TEST, ALLISON JENNA 137 SOUTH ST HOLLISTER, MO 65672-9773 County: TANEY (417) 335-8540

CLIENT	PROVIDER	FINANCIAL	ADMINISTRATIVE
--------	----------	-----------	----------------

[Show Instructions](#)

Submit Form

Client Information — Please verify address and demographics below and update as needed.

Client Name / SSN	TEST, ALLISON JENNA	?	View/Edit Client Information	
Address	137 SOUTH ST		SSN	490-06-8621
			DOB	10/24/1991
			DCN	29650349
			Sex	FEMALE
			Race	WHITE
			Ethnicity	NON HISPANIC
City, State Zip	HOLLISTER	MO	65672-9773	Phone 417 - 335 - 8540
				☐ No Phone

Provider Information

	☐ Regular Billing ☐ Direct Billing	
Provider		Referring Provider
Service Name/Address		

Form Type/Version

Type		Create Form Close
Version		

To edit,
select
“View/Edit
Client
Information”

FORM ENTRY INTO MOHSAIC

The screenshot shows the 'State of Missouri DEPARTMENT OF HEALTH AND SENIOR SERVICES' web application. The 'Current Client: None Selected' status is displayed. The interface includes tabs for CLIENT, PROVIDER, FINANCIAL, and ADMINISTRATIVE. A navigation bar contains links for SUBMIT NEW FORMS / BILLING, VIEW MEDICAID INFORMATION, and VIEW MONTHLY REPORTS. A 'Show Instructions' link is also present. The main section is titled 'Submit Form' and contains a 'Client Information' section with fields for Client Name / SSN (containing 'test, z'), Address, City, State, and Zip. Below this is a 'Provider Information' section with fields for Provider Name, Service Name/Address, and a 'Loading...' status. At the bottom, there is a 'Form Type/Version' section with dropdown menus for Type and Version, and 'Create Form' and 'Close' buttons. A modal dialog box is overlaid on the form, displaying the message: 'healthappstest.dhss.mo.gov says The client was NOT found in MOHSAIC. Click OK to add the client. Click CANCEL to search again.' The dialog has 'OK' and 'Cancel' buttons.

State of Missouri
DEPARTMENT OF HEALTH AND SENIOR SERVICES

Current Client: None Selected

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

SUBMIT NEW FORMS / BILLING VIEW MEDICAID INFORMATION VIEW MONTHLY REPORTS

Show Instructions

Submit Form

Client Information

Client Name / SSN test, z ?

Address

City, State Zip

Provider Information

Provider Name Loading...

Service Name/Address

Form Type/Version

Type

Version

Create Form Close

healthappstest.dhss.mo.gov says

The client was NOT found in MOHSAIC. Click OK to add the client. Click CANCEL to search again.

OK Cancel

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

FORM ENTRY INTO MOHSAIC

State of Missouri
DEPARTMENT OF HEALTH AND SENIOR SERVICES

Current Client: None Selected

CLIENT PROVIDER FINANCIAL

[SUBMIT NEW FORMS / BILLING](#) [VIEW MEDICAID INFORMATION](#)

[Show Instructions](#)

Submit Form

Client Information

Client Name / SSN

Address

City, State Zip

Provider Information

☐ Regular Billing ☐ Direct Billing

Provider

Service Name/Address

Form Type/Version

Type

Version

[Show Instructions](#)

Search Person

PartyInformation 6.2.0.0
Build Date: 5/16/2025
PartyInformation/Search.aspx

☐ **Name Search**

Last Name: * TEST

Middle Name:

Date of Birth: 05/18/1988

Ethnicity: NON HISPANIC

Search Type: ☒ LIKE ☐ SOUNDEX ☐ BOTH

Race:

☐ White ☐ Asian
☐ Black ☐ American Indian
☒ Unknown ☐ Pacific Islander

First Name: * Zinger

Suffix: **Prefix:**

Gender: FEMALE

Role: MEDICAL CLIEI

☐ **DCN Search**

☐ **SSN Search**

DCN:

SSN:

[Search](#) | [Register as Medical Client](#) | [Modify Search](#) | [Cancel](#)

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

FORM ENTRY INTO MOHSAIC

State of Missouri		DEPARTMENT OF HEALTH AND SENIOR SERVICES		SHOW ME HEALTHY MISSOURI	
Current Client: TELLER, GEMMA L 270703 VISTA HERMITAGE, MO 65011 (323) 444-8888					
CLIENT		PROVIDER		FINANCIAL ADMINISTRATIVE	
Show Instructions					
Submit Form					
Client Information -- Please verify address and demographics below and update as needed.					
Client Name / SSN		TELLER, GEMMA L ?		View/Edit Client Information	
Address		270703 VISTA		SSN 478-55-9648 DOB 3/27/1967 DCN 65552936	
				Sex FEMALE Race WHITE Ethnicity NON HISPANIC	
City, State Zip		HERMITAGE , MO 65011		Phone 323 - 444 - 8888 ☐ No Phone	
Provider Information					
☒ Regular Billing ☐ Direct Billing					
Provider		WRIGHT COUNTY HEALTH DEPARTMENT		Referring Provider	
Service Name/Address		WRIGHT COUNTY HEALTH DEPT - MOUNTAIN GROVE - 602 E STATE ST STE B, MOUNTAIN GROVE, MO 65711-1826			
Form Type/Version					
Type		Patient History (Green)			
Version		Forms for Services Provided On or After June 30, 2025			
				Create Form Close	

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

A. PERSONAL DATA				Ver. - 82
Name (Last, First, Middle Initial)		TELLER, GEMMA L		
County at TOV:				
Maiden Name				
Age (Years): 58	Date of Birth	Social Security Number	Medicaid DCN/Medicare Number	
	3/27/1967	478-55-9648	65552936	
Date Form Received:		06/25/2025	MM/DD/YYYY	
Client Eligibility Verified		Insurance Coverage		
		Type of Medicare		
Height		ft	in	Weight
				lbs. BMI
B. CLINICAL BREAST EXAM RESULTS Clear				
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		

Visit Type

Initial

Annual

Rescreen

Annual CBE only

Initial CBE only

Mammogram only

Navigation Only

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.

Annual CBE only		Visit Type
☐	Referral Fee	
☒	Telehealth Visit	07/01/2025 MM/DD/YYYY

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	Social Security Number	Medicaid DCN/Medicare Number	
Age (Years): 58	3/27/1967	478-55-9648	65552936
Date Form Received: 06/25/2025		MM/DD/YYYY	
Mammogram only		Visit Type	
Referral Fee		Telehealth Visit	
Yes		No	
Client Eligibility Verified		Insurance Coverage	
Yes		No	
Deductible Met		Type of Medicare	
Height		Weight	
ft		lbs.	
in		BMI	
Blood Pressure		Average	
1st Reading		2nd Reading	
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			
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			
High Risk for Breast Cancer			
1) Yes 2) No 9) Not assessed/Unknown			
Rescreen Planned (less than 10 months)			
MM/YYYY			
Diagnostic Work-up Planned (must be less than 60 days)			
MM/YYYY			

Show Me Healthy Women

MAMMOGRAM RESULTS [Clear](#) Reporting Only

☐ (4) Mammogram not done: OR CBE done and diagnostic workup pending

☒ (1) Routine screening mammogram

☐ (2) Mammogram performed to evaluate symptoms:

☐ (5) Cervical record only, no breast service provided

☐ (6) Referred to Direct Biller for Mammogram

☐ (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

☐ Personal history of breast cancer

☐ Previous abnormal mammogram results (rescreen)

Date Client Referred for diagnosis

Mammogram Provider Facility ☒ Mammogram Van

Previous Mammograms

Date of Last Mammogram month year

Date of This Mammogram MM/DD/YYYY

Type of Mammogram ☒ Screening ☐ Diagnostic [Clear](#)

☐ Conventional ☒ Digital ☒ Tomosynthesis

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		Social Security Number		Medicaid/DCN/Medicare Number							
Age (Years): 58		3/27/1967		478-55-9648		65552936					
Date Form Received:			06/25/2025			MM/DD/YYYY					
Rescreen			Visit Type								
Referral Fee			MM/DD/YYYY								
Client Eligibility Verified			No			Insurance Coverage					
Deductible Met			Type of Medicare								
Height		5		ft		5		in			
Weight		150		lbs.		BMI 24.96		Blood Pressure			
120		/		70		122		/		68	
1st Reading		2nd Reading		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: / / CLIENT ELIGIBILITY VERIFIED: ☐ Yes ☐ No INSURANCE COVERAGE: ☐ Yes ☐ No SUBSIDIZABLE MET: ☐ Yes ☐ No REFERRAL TYPE: ☐ Part A ☐ Part A and B

MBT TYPE: ☐ Initial ☐ Annual ☐ Rescreen ☐ Mammogram only ☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only

B. BREAST CANCER SCREENING

B.1. Does client report any SBE symptoms? ☐ Yes ☐ No (If "Yes" complete B.2.) Date of CBE: / /

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 ☐ (4A) Pain/Tenderness - 1st occurrence ☐ (4B) Pain/Tenderness - 2nd occurrence

☐ (2) Nipple discharge ☐ (5) Other (specify):

☐ (3) Skin changes (dimpling, retraction, new nipple inversion, ulceration, Paget's disease)

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

☐ Yes ☐ No

☐ (1) Benign finding (fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)

☐ (2) Discrete palpable mass (includes masses that may be diffuse, poorly defined thickening, cystic or solid)

☐ (3) Skin dimpling/retraction, new nipple inversion, peau d'orange, ulceration, one breast lower than usual, prominent veins, unilateral, unusual increase in size, unilateral

☐ (4) Enlarged, tender, hard or hard palpable supraclavicular, infraclavicular or axillary lymph nodes, also swelling of upper arm

☐ (5) Breast pain and tenderness

☐ (6) Not assessed/Unknown

B.4. High Risk for Breast Cancer ☐ (1) Yes ☐ (2) No ☐ (3) Not assessed/Unknown

Rescreen CBE Planned ☐ Yes ☐ No / /

Diagnostic Work-up Planned ☐ Yes ☐ No / /

B.5. Mammogram Results

☐ (1) Mammogram not done or CBE done and diagnostic work-up planned

☐ (2) Routine screening mammogram

☐ (3) Mammogram performed to evaluate symptoms

☐ (4) Personal history of breast cancer

☐ (5) Previous abnormal mammogram results (rescreen)

☐ (6) Cervical record only, no breast service provided

☐ (7) Referred to died later

☐ (8) Abnormal mammogram done by a non-program funded provider; patient referred for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

☐ (9) Abnormal mammogram done by a non-program funded provider; patient referred for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

Date client referred for diagnosis: / /

Mammography provider facility (city/county): ☐ 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 Suspicious of Malignancy (Category 5) ☐ (6) Unassessable (Category 6) ☐ (7) Unassessable-out interpreted, repeat (Not Field) ☐ (8) Unassessable-out interpreted, repeat (Not Field)

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

Rescreen mammogram planned: ☐ Yes ☐ No (must be less than 6 months)

Diagnostic work-up planned: ☐ Yes ☐ No (must be less than 60 days)

Referred for diagnostic testing/direct MBI (physician/facility name): / /

☐ MBI (High Risk ONLY - Prior authorization required) Report L/R results in Section C, Comments. / /

MO 685-1788 (5-18) Ch. 01

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

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: / / CLIENT ELIGIBILITY VERIFIED: ☐ Yes ☐ No INSURANCE COVERAGE: ☐ Yes ☐ No SUBSIDIZABLE MET: ☐ Yes ☐ No REFERRAL TYPE: ☐ Part A ☐ Part A and B

MBT TYPE: ☐ Initial ☐ Annual ☐ Rescreen ☐ Mammogram only ☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only

B. BREAST DIAGNOSTIC PROCEDURES

Diagnostic Mammogram ☐ Conventional ☐ Digital ☐ Tomosynthesis

Additional Mammographic views:

Normal ☐ (1) Negative (Category 1) ☐ (2) Benign Finding (Category 2)

Abnormal ☐ (3) Probably Benign (Category 3) ☐ (4) Suspicious Abnormality (Category 4) ☐ (5) Highly Suspicious of Malignancy (Category 5) ☐ (6) Unassessable (Category 6) ☐ (7) Unassessable-out interpreted, repeat (Not Field) ☐ (8) Unassessable-out interpreted, repeat (Not Field)

Ultrasound ☐ Rescreen ☐ Reporting only

Left: Right

Normal ☐ (1) Negative (Category 1) ☐ (2) Benign Finding (Category 2)

Abnormal ☐ (3) Probably Benign (Category 3) ☐ (4) Suspicious Abnormality (Category 4) ☐ (5) Highly Suspicious of Malignancy (Category 5) ☐ (6) Unassessable (Category 6) ☐ (7) Unassessable-out interpreted, repeat (Not Field) ☐ (8) Unassessable-out interpreted, repeat (Not Field)

Specialist Consultation (date): / /

Diagnostic Work-up Planned: ☐ None ☐ 6-60 days ☐ 91-99 days ☐ Reporting only

CBE WNL ☐ Yes ☐ No (If "Yes" 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 scaldness 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, hard or hard palpable supraclavicular, infraclavicular or axillary lymph nodes, also swelling of upper arm

Final Radiologist Interpretation (Type/Category) ☐ Yes ☐ No ☐ Reporting only

Left Breast: Type: ☐ Superficial ☐ Deep tissue within glandular ☐ Penetration ☐ Additional Lesion

Result: ☐ (1) Negative ☐ (2) Indeterminate ☐ (3) Suspicious for Malignancy - Refer to BCCT ☐ (4) Malignancy - Refer to BCCT

Right Breast: Type: ☐ Superficial ☐ Deep tissue within glandular ☐ Penetration ☐ Additional Lesion

Result: ☐ (1) Negative ☐ (2) Indeterminate ☐ (3) Suspicious for Malignancy - Refer to BCCT ☐ (4) Malignancy - Refer to BCCT

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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.

Incisional, No Guidance (19101) ☐ Mammogram Guided(19281) ☐ No Add'l Sec Pathology ☐

125) ☐ Stereotactic Guided(19283) ☐ 1 Add'l Sec Pathology ☐

☐ US Guided(19285) ☐ 2 Add'l Sec Pathology ☐

Number of Add'l Lesions (19282, 19284, 19286)

☐ Immunohistochemistry, Initial (88342) Immunohistochemistry, Additional (88341)

☐ Radiological Exam of Specimen?(76098)

Status of Final Diagnosis

☐ (1) Work-up complete (Complete Section C)

☐ (2) Work-up Pending

☒ (3) Lost to Follow-up

☐ (4) Work-up refused (Describe in comment section/Must have signed waiver)

☐ (9) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY)

Status of Final Diagnosis Date (MM/DD/YYYY)

Next Breast Cancer Screening Date MM/YYYY

EXAMPLE OF LOST TO FOLLOW UP

Diagnostic Breast

☐ Incisional, No Guidance (19101) ☐ Excisional(19120 or 19125) Add'l Lesions (19126)	☐ Mammogram Guided(19281) ☐ Stereotactic Guided(19283) ☐ US Guided(19285) Number of Add'l Lesions (19282, 19284, 19286) ☐ Immunohistochemistry, Initial (88342) Immunohistochemistry, Additional (88341) ☐ Radiological Exam of Specimen?(76098)	☐ No Add'l Sec Pathology ☐ 1 Add'l Sec Pathology ☐ 2 Add'l Sec Pathology ☐ 3 Add'l Sec Pathology
Additional Facility Fee		
☐ (1) Benign ☐ (2) Benign/Atypical ☐ (3) Indeterminate ☐ (4) Malignancy Biopsy Result (Report only most severe result)	☐ (1) Work-up complete (Complete Section C) ☐ (2) Work-up Pending ☒ (3) Lost to Follow-up ☐ (4) Work-up refused (Describe in comment section/Must have signed waiver) ☐ (9) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY) Status of Final Diagnosis	Status of Final Diagnosis Date (MM/DD/YYYY) 05/04/2023
Next Breast Cancer Screening Date MM/YYYY		
Other Procedure (select)		
☐ Cytology for Nipple Discharge(Not Reimbursed) ☐ MRI (Not Reimbursed) ☐ Nuclear Scan/Miraluma/BSGI (Not Reimbursed) ☐ Skin Biopsy(Not Reimbursed) ☐ Ductogram ☐ Single Duct(77053) ☐ Multiple Duct(77054 Not Reimbursed) Left ☐ Single Duct(77053) ☐ Multiple Duct(77054 Not Reimbursed) Right Right ☐ (1) ☐ (1) Negative(Category 1)		

Diagnostic Cervical

Status of Final Diagnosis ☐ (1) Work-up complete (Complete Section C) ☐ (2) Work-up Pending ☒ (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date) ☐ (4) Work-up refused (Describe in comment section/Must have signed waiver) ☐ (5) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY) Status of Final Diagnosis Date (MM/DD/YYYY) 05/04/2023
C. CERVICAL DIAGNOSIS
Final Diagnosis
☐ Normal/Benign Reactive/Inflammation ☐ HPV/Condylomata ☐ CIN I/Mild Dysplasia/Low grade SIL (Biopsy Diagnosed) ☐ CIN II/Moderate Dysplasia (Biopsy Diagnosed)* refer to BCCT ☐ CIN III/Severe Dysplasia/High Grade SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)* ☐ Invasive (Biopsy Diagnosed)* ☐ Other (Use if woman has no cervix for cancer types: Vulval, Vaginal, Endometrial, Uterine, Ovarian)

TRANSPORTATION

 FREE Breast and Cervical Cancer Screening Program <i>Removing barriers to life saving cancer screenings for women.</i>	Transportation Voucher County: _____ Trip Date: _____ Appointment Time: _____ Client Signature: _____ Clinic Signature: _____
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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

Does client report any breast symptoms?	No	Additional Information Required if "YES" Selected
CBE WNL	Yes	Additional Information Required if "NO" Selected
Findings Present at CBE (check only one)		
BENIGN FINDING: ☒ Within Normal Limits		
☐ 1) Benign finding (fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)		
SUSPICIOUS FOR CANCER (Any marked findings requires completion of two(2) diagnostic procedures entered on purple breast diagnostic form)		
Date of CBE	5/19/2025	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
C. MAMMOGRAM RESULTS Clear ☐ Reporting Only		
☐ (4) Mammogram not done. OR CBE done and diagnostic workup pending		
☒ (1) Routine screening mammogram		
☐ (5) Cervical record only, no breast service provided		
☐ (6) Referred to Direct Biller for Mammogram		
☐ (3) Abnormal mammogram done by a non-program		

Diagnostic Breast

Diagnostic Mammogram		
☐ Conventional ☒ Digital ☒ Tomosynthesis Clear		
5/10/2025 MM/DD/YYYY		
Additional Mammographic Views		
L R Clear		
Normal	☒ 1	☒ (1) Negative (Category 1)
	☐ 2	☐ (2) Benign Finding (Category 2)
	☐ 3	☐ (3) Probably Benign (Category 3)
	☐ 4	☐ (4) Suspicious Abnormality (Category 4)
Abnormal	☐ 5	☐ (5) Highly Suggestive of Malignancy (Category 5)
	☐ 14	☐ (14) Additional Imaging Pending (Category 0)
Other	☐ 7	☐ (7) Unsatisfactory - not interpreted - repeat (not paid)
Ultrasound	5/10/2025	MM/DD/YYYY Clear ☐ Rescreen
L R		
Left:	☒ Complete	☒ 1 ☒ (1) Negative (Category 1)
	☐ Limited	☐ 2 ☐ (2) Benign (Category 2)
Right:	☒ Complete	☐ 3 ☐ (3) Probably Benign (Category 3)

INCOMPLETE FORM EXAMPLE

SMHW PAP Test Result (Select one)	
NORMAL	☐ (1) Negative for Intraepithelial Lesion or Malignancy
	☐ (2) Infection/Inflammation/Reactive Changes
ABNORMAL	☒ (3) Atypical Squamous Cells of Undetermined Significance (ASC-US) (May have HPV test)
Clear	☐ (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 v (Pelvic Exam and Pap Test Result or Indication for HPV Test Required)
Endocervical Cells	Yes v
HPV Profile:	08/10/2025 MM/DD/YYYY ☐ Reporting Only
Indication for HPV Test:	(1) Cotesting/Screening v Clear
Indication for HPV Self-collection Test:	v Clear
Self-collection Kit	☐ BD Onclarity ☐ Roche Cobas
Clear	HPV Test Result Positive(High Risk) v HPV DNA Genotyping 16 or 18 POSITIVE ☐ YES ☐ NO ☐ NOT DONE
Rescreen Planned (less than 10 months)	No v MM/YYYY
Diagnostic Work-up Planned (Must be less than 60 days)	Yes v 09/2025 MM/YYYY
Referred for Diagnostic Work-up / Direct Biller	Physician / Facility Name XYZ CLINIC

Indication for HPV Test:	(1) Cotesting/Screening v Clear
Clear	HPV Test Result Positive(High Risk) v 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)

Six CDC required services:

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graph TD; A[Six CDC required services:] --- B[Written assessment of patient barriers to cancer screening]; A --- C[Patient education and support]; A --- D[Resolution of barriers to obtaining screening]; A --- E[Patient tracking and follow-up]; A --- F[Minimum of two (2) preferably more, patient contacts]; A --- G[Data collection to evaluate outcomes of patient navigation];
```

Written
assessment of
patient barriers to
cancer screening

Patient education
and support

Resolution of
barriers to
obtaining
screening

Patient tracking
and follow-up

Minimum of two
(2) preferably
more, patient
contacts

Data collection to
evaluate outcomes
of patient
navigation

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Show Me Healthy Women



Missouri Department of Health & Senior Services

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