



# CERVICAL SERVICES FORM

## Women's Health Connection Program, Nevada State Health Division

Case Management Unit  
 Las Vegas Office: (702) 486-6260  
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 (800) 992-0900, Ext. 486-6260

Client Information	
NAME: _____	
ADDRESS: _____	
_____	
DOB: _____	PHONE: _____

I	<b>Pelvic Exam and/or Pap Test</b> (Instructions for use of this form printed on reverse)
	<input type="checkbox"/> Pelvic Exam      Date of Exam: _____ Findings: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Cervix (suspicious for cervical cancer) <input type="checkbox"/> Other Findings: _____
	<input type="checkbox"/> <b>Pap Test</b> Check reason below for Pap test: <input type="checkbox"/> Patient under surveillance for previous abnormal test      Date of prior abnormal Pap test: _____ <input type="checkbox"/> Patient under surveillance following cervical diagnostic work up without indication for treatment <input type="checkbox"/> Patient under surveillance following treatment precancerous or cancerous cervical condition
	<input type="checkbox"/> Consultation of abnormal cervical finding      Date of Consultation: _____ Abnormal Finding is: _____      Date of Abnormal Finding: _____
	<b>Cervical Work Up is</b> <input type="checkbox"/> Not Planned <input type="checkbox"/> Planned: Name of Specialist Provider: _____      Date of Referral: _____
	<b>Clinician Signature:</b> _____ <b>Date:</b> _____ <b>Print Name of Clinic Location:</b> _____

II	<b>Diagnostic Workup of Abnormal Cervical Finding</b> (Instructions for use of this form printed on reverse)
	<u>Check All Procedures Performed:</u> <u>Date Procedure(s) Performed:</u> _____ <input type="checkbox"/> Consult and repeat pelvic exam      Findings: <input type="checkbox"/> Normal Exam <input type="checkbox"/> Benign <input type="checkbox"/> Positive Suspicious for Cervical Cancer <input type="checkbox"/> Consult Recommendation: _____ <input type="checkbox"/> Colposcopy with biopsy(s) <input type="checkbox"/> Colposcopy without biopsy <input type="checkbox"/> Endocervical curettage <input type="checkbox"/> Other: _____
	<b><u>The following procedures may be performed with PRIOR AUTHORIZATION:</u></b> <input type="checkbox"/> Diagnostic Loop Electrode Excision <input type="checkbox"/> Cold knife conization
	<b><u>Final Diagnosis</u></b> <input type="checkbox"/> Negative/benign reaction/Inflammation <input type="checkbox"/> CIN1/ mild dysplasia <input type="checkbox"/> Other nonmalignant condition (HPV, Inflammation) <input type="checkbox"/> CIN2 /moderate dysplasia <input type="checkbox"/> HPV/Condylomata /Atypia <input type="checkbox"/> CIN3/severe dysplasia /Carcinoma in Situ (Stage 0)/Adenocarcinoma in Situ <input type="checkbox"/> Low Grade SIL <input type="checkbox"/> High Grade SIL <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Invasive Cervical Carcinoma/Adenocarcinoma: Stage at Diagnosis: _____ <input type="checkbox"/> Other _____
	<b><u>Treatment</u></b> <input type="checkbox"/> Not indicated: Resume routine screening <input type="checkbox"/> Cryosurgery <input type="checkbox"/> LEEP <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Not indicated: Short term follow-up <input type="checkbox"/> Conization      Other: _____
	<b>Clinician Signature:</b> _____ <b>Date:</b> _____ <b>Print Name of Clinic Location:</b> _____

## Instructions for Using the Cervical Services Form

1. Use this form when performing additional WHC Program covered cervical services to include:
  - a. Discussion of an abnormal cervical finding or Pap test result as defined in the box below.
  - b. Performing surveillance for a previous abnormal test as defined in the box below.
  - c. Performing a cervical diagnostic work up on a patient with a program covered abnormal cervical finding.
  - d. Discussion of the results of a completed cervical diagnostic work up in order to establish the treatment plan of care.
  - e. Performing surveillance following treatment of a precancerous or cancerous cervical condition.
2. Fill out Section I and/or II as appropriate.
3. The clinician must sign and date the form in the section that is filled out.
4. The clinic's name must be written legibly in the section that is filled out.
5. Make a copy of this form and give it to the client when referring to a WHC Program provider if that provider is different than the screening provider.
6. Attach a copy of this document with the Health Insurance Claim (HICF) form when requesting reimbursement for services.

### COVERED SERVICES

The Women's Health Connection (WHC) Program will pay for cervical work up for eligible women for the following abnormal cervical findings:

- Abnormal cervix suspicious for cervical cancer.
- Abnormal Pap test results to include:
  - Atypical squamous cells of undetermined significance (ASC-US).
  - Atypical squamous cells of undetermined significance cannot exclude high grade disease (ASC-H).
  - Low grade squamous intraepithelial lesions (LSIL).
  - High grade squamous intraepithelial lesions (HSIL).
  - Atypical glandular cell or atypical glandular cells of undetermined significance (AGC)

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