Utah State Department of Health
BUREAU OF HEALTH PROMOTION
Box 142107
Salt Lake City, Utah 84114-2107
Telephone: (801) 538-6712 or 1-800-717-1811
Fax: (801) 538-9495

Utah Cancer Control Program
A Joint Program of the Utah Department of Health and Utah's Local Health Departments

PROVIDER AGREEMENT: OB/GYN

Provider name: _____

Medical License No: _____

Address: _____
(street) (city) (zip) (county)

Contact Person: _____ Telephone: _____

I would like to participate in the breast and cervical cancer-screening program administered by the Utah Cancer Control Program (UCCP) within the Utah Department of Health (UDOH). I understand that women with abnormal pelvic exams or abnormal screening Pap tests will be referred to me. I also understand that any woman who is referred to me becomes my patient and that I am responsible for determining which of the diagnostic services listed below will be provided to her and for informing the patient of all test results.

I agree to accept reimbursement from the UDOH at the set rates for the following diagnostic procedures:

CPT code 99201
Office visit (new patient)
$32.00

CPT code 99202
Office visit (new patient)
$59.00

CPT code 99203
Office visit (new patient)
$90.00

CPT code 99211
Office visit (follow-up)
$17.00

CPT code 99212
Office visit (follow-up)
$35.00

CPT code 99213
Office visit (follow-up)
$57.00

CPT code 57452
Colposcopy without biopsy
$99.00

CPT code 57454
Colposcopy with biopsy
$140.00

CPT code 57460
Colpo of cervix-loop electrode
$263.00

CPT code 57461
Colpo w/loop electrode
biopsy of cervix$170.00
$263.00

CPT code 57500
Biopsy, with or w/out fulguration
$116.00

CPT code 57505
Excision, endocervical curettage
$91.00

CPT code 57520
Conization of cervix
$280.00

CPT code 57522
Loop electrode excision
$238.00

CPT code 58100
Endometrial sampling
$100.00

I understand that the UDOH will only pay for the services indicated by the CPT codes listed above and that the rates of reimbursement stated above must be accepted by me as payment in full for services rendered.
I also agree to bill the patients insurance first (when applicable) before billing the UCCP for any services rendered.

As a participating provider, I agree to submit medical reports (diagnostic and progress notes) to the UCCP for each patient referred to me within 15 days of having her case completed. I understand that reimbursement is contingent upon receipt of this form by the UDOH. I understand that the patients referred to me have consented that I may share information related to their medical care with the UDOH.

The service period for this agreement will be ongoing from March 1, 2010 unless terminated or extended by agreement in accordance with the terms and conditions of this Provider Agreement. This agreement may be ended at any time with 30 days written notice from either the provider or the UDOH. This agreement is contingent upon the provider's certification as a physician licensed in the state by the Utah Department of Commerce, Division of Occupational and Professional Licensing.

Physician Signature: _____ Date: _____

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