



REQUEST FOR FUNDING - DIAGNOSTIC AND FOLLOW-UP SERVICES

DATE: _____

FACILITY/ORGANIZATION NAME: _____

REQUESTED BY: _____ PHONE # _____ FAX # _____

PATIENT ID # _____ (Do not release names of patients to IBCAT due to HIPPA)

Was this patient screened through your IBCAT Grant? Y/N (please circle one)

If not, please indicate how screening mammogram was funded (ie. self-pay, insurance, other grant funds, etc.)

Service Description	CPT	IBCAT Reimbursement Rate*	Approved by IBCAT	Unable to Fund
_____ Diagnostic Mammogram - Film	(77056)	\$106.55	_____	_____
_____ Unilateral Mammogram - Film	(77055)	\$83.34	_____	_____
_____ Digital Diagnostic Mammogram	(G0204)	\$161.18	_____	_____
_____ Digital Unilateral Mammogram	(G0206)	\$127.56	_____	_____
_____ Ultrasound	(76645)	\$92.53	_____	_____
_____ Stereotactic Biopsy (77031/19103/ 19295)		\$764.69	_____	_____
_____ Ultrasound Biopsy (76942/ 19102)		\$393.76	_____	_____
_____ Pathology	(88305)	\$102.30	_____	_____

***If the Grantee is not the service provider, IBCAT will reimburse at either the stated rate or the rate stated on the Provider Letter of Agreement with the organization, whichever is less.**

Instructions for Requesting Funding

1. Complete this form and fax to IBCAT office at 812.868.8773.
2. Form will be returned to requester via fax.
3. If the request is funded, a copy of this request form MUST accompany invoice sent to IBCAT.