



Utah State Department of Health
BUREAU OF HEALTH PROMOTION
Box 142107
Salt Lake City, Utah 84114-2107
Telephone: (801) 538-6157 or 1-800-717-1811
Fax: (801) 237-0775

PROVIDER AGREEMENT: SURGEON

Provider Name: _____

Medical License No: _____ NPI: _____

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

Contact Person: _____ Telephone: _____

Email: _____ Fax: _____

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 those women with abnormal clinical breast exams or abnormal screening mammograms 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 provide services at a maximum reimbursement rate set forth in Attachment A, and that the rate of reimbursement stated in Attachment A must be accepted by me as payment in full for services rendered. I agree to bill patient's insurance first (when applicable) before billing the UCCP for any services rendered. If the amount paid by the insurance is less than the reimbursement rates listed herein, I may bill UCCP for the difference. UCCP will provide an update Attachment A, every March on an annual basis. I agree to not bill patients for any additional charges or other CPT codes during the referral visit. I understand that I could use my contracting laboratory for biopsy specimens and that the UDOH will reimburse only the pathologist's fee (CPT 88305), but not the facility.

As a participating provider, I agree to submit a completed Breast Referral Form (Attachment B) to the UCCP for each patient referred to me within 15 days of final examination. I understand that reimbursement is contingent upon receipt of this form by the UCCP. I understand that the patients referred to me have consented that I may share information related to their medical care with the UCCP.

The service period for this agreement will be ongoing from date of signing unless terminated or extended by agreement in accordance with the terms and conditions of this Provider Agreement. This agreement may be terminated 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.

Physicians Signature _____ Date: _____

UCCP Contact Information	
Utah Cancer Control Program (UCCP)	1-800-717-1811 801-538-6157
Address: PO Box 142107, Salt Lake City Utah 84114-2107	
Email: uccpmedicalrecords@utah.gov	
Main Fax:	801-237-0775
Billing Phone:	801-538-6230
Billing Fax:	801-237-0769

Attachment A
UTAH CANCER CONTROL PROGRAM
Payable
Surgeon CPT Codes and Reimbursement rates
2021

SERVICES PROVIDED

CPT	PROCEDURES	UCCP RATE
10021	Fine needle aspiration without imaging guidance, first lesion	\$99.17
10004	Fine needle aspiration with imaging guidance, each addt'l lesion	\$49.90
10005	Fine needle aspiration biopsy including ultrasound guidance, first lesion	\$131.44
10006	Fine needle aspiration biopsy including ultrasound guidance, each addt'l first lesion	\$59.17
10007	Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	\$294.84
10008	Fine needle aspiration biopsy including fluoroscopic guidance, each addt'l first lesion	\$157.12
10009	Fine needle aspiration biopsy including CT guidance, first lesion	\$451.56
10010	Fine needle aspiration biopsy including CT guidance, each addt'l first lesion	\$267.62
19000	Aspiration of Cyst of Breast	\$103.57
19001	Aspiration of Cyst of Breast, Additional	\$26.31
19100*	Biopsy of breast, needle core (surgical procedure only)	\$152.41
19101*	Incisional biopsy of breast	\$331.83
19120*	Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion.	\$502.09
19125*	Excision of breast lesion identified by pre-operative placement of radiological marker-single lesion.	\$553.73
19126	Excision of breast lesion identified by pre-operative placement of radiological marker-additional lesion.	\$157.30
99202	New patient – Office visit (20 minutes face to face)	\$70.23
99203	New patient – Office visit (30 minutes face to face)	\$108.43
99211	Established patient – Office visit (5 minute face to face)	\$21.63
99212	Established patient – Office visit (10 minute face to face)	\$54.04
99213	Established patient – Office visit (15 minutes face to face)	\$88.23
99214	Established patient – Office visit (25 minutes face to face)	\$125.41

* **Pre-approval** for use of these diagnostic codes needs to be obtained from the state. Please call the Utah Cancer Control Program at (801)538-6157 or 1-800-717-1811 to obtain approval for **each patient**.