STATE OF ALABAMA
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER
STATE COMPTROLLER'S OFFICE

INSTRUCTIONS: In order to receive payment by the State of Alabama, a correct tax identification number, name and address must be in our files. Please complete and return this form as soon as possible to:

ALABAMA DEPARTMENT OF PUBLIC HEALTH
P.O. BOX 303017, MONTGOMERY, AL 36130-3017

Part 1 – TAXPAYER IDENTIFICATION NUMBER, NAME AND ADDRESS

Identification Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Check One:
___ **Federal Employer Identification Number (FEIN)**
___ **Social Security Number (SSN)**

Name: _____

Address: _____

_____

_____

Part 2 – Circle the designation that identifies your type of trade or business.

1 – CORPORATION, PROFESSIONAL ASSOCIATION OR PROFESSIONAL CORPORATION. (A corporation formed under the laws of any state within the U.S.)
2 – NOT FOR PROFIT CORPORATION (Section 501 (e) (3))
3 – PARTNERSHIP, JOINT VENTURE, ESTATE OR TRUST
4 – SOLE PROPRIERTORSHIP OR SELF-EMPLOYED (ID number must be SSN)
5 - NON CORPORATE RENTAL AGENT
6 – GOVERNMENTAL ENTITY (City, State or U.S. Government)
7 – FOREIGN CORPORARTION OR FOREIGN NATIONAL OR OTHER FOREIGHN ENTITY.

NOTE: Failure to complete and return this form may subject you to backup withholding in the amount of 20% of future payments pursuant to Section 3406, Internal Revenue Code.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE EXAMINED THIS REQUEST AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, AND COMLETE.

_____ _____ (_____)_____
SIGNATURE **DATE** **TELEPHONE**

_____
TITLE

PLEASE INCLUDE FEDERAL IDENTIFICATION NUMBER ON ALL INVOICES

State of Alabama

Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Department of Public Health, Breast & Cervical Cancer Early Detection Program

ADDRESS

201 Monroe Street, Suite 1350

CITY, STATE, ZIP

Montgomery, AL 36104

TELEPHONE NUMBER

(334) 206-5538

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

OVER

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

FORM FOR SECTIONS 9 (a) and (b) BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT; CODE OF ALABAMA, SECTIONS 31-13-9 (a) and (b)

AFFIDAVIT FOR BUSINESS ENTITY/EMPLOYER /CONTRACTOR
(To be completed as a condition for the award of any contract, grant, or incentive by the State of Alabama, any political subdivision thereof, or any state-funded entity to a business entity or employer that employs one or more employees)

State of _____

County of _____

Before me, a notary public, personally appeared _____ (print name) who, being duly sworn, says as follows:

As a condition for the award of any contract, grant, or incentive by the State of Alabama, any political subdivision thereof, or any state-funded entity to a business entity or employer that employs one or more employees, I hereby attest that in my capacity as _____(state position) for _____ _____ (state business entity/employer/contractor name) that said business entity/employer/contractor shall not knowingly employ, hire for employment, or continue to employ an unauthorized alien.

I further attest that said business entity/employer/contractor is enrolled in the E-Verify program. (ATTACH DOCUMENTATION ESTABLISHING THAT BUSINESS ENTITY/EMPLOYER/CONTRACTOR IS ENROLLED IN THE E-VERIFY PROGRAM)

_____Signature of Affiant

Sworn to and subscribed before me this _____day of _____, 2____.

I certify that the affiant is known (or made known) to me to be the identical party he or she claims to be.

_____Signature and Seal of Notary Public

IMMIGRATION STATUS

I hereby attest that all workers on this project are either citizens of the Unites States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

_____
Signature of Contractor

_____
Witness

Breast & Cervical CANCER EARLY DETECTION Program of Alabama

PROVIDER CHECKLIST

As part of the ABCCEDP contracting process, please complete the following table and provide copies of all licenses. This form along with all required copies of documents must be returned with the signed contract.

Name of Physician, Practice or Facility	
Tax ID Number	
UPIN Number	
MQSA Certification # for Mamm Providers	
CLIA Lab Certification # for Labs	
Street Address (physical site address)	
City, State, Zip	
Mailing Address for **Receipt of Payments**	
Mailing City, State Zip	
Practice E-Mail Address	
Main Telephone Number	
FAX Number	
ABCCEDP HOTLINE NUMBER	
BILLING Contact Person/Phone Number	
CONTRACTING Contact Person/Phone Number	
PRACTICE MANAGER Name/Phone Number	

Number of Physicians	
Number of Registered Nurses	
Number of Nurse Practitioners	
Number of Physician Assistants	
Number of Nurse Anesthetists	
Number of Cytologists	
Number of Radiologic Technologists	
Number of Certified Mammographers	
Method of PAP Collection (select all that apply)	□ Thin Prep □ Slide □ Other
Do you now or do you plan to offer separate HPV testing?	□ Yes □ No □ Not Now
Attach Legible Copy of license for each Physician, RN, CRNP, PA, Rad Tech, Mammographer, Cytologist & Nurse Anesthetist	
Name of Lab Used (if not a lab)	
Are patients billed separately for lab procedures?	□ Yes □ No
Attach Legible Copy of Usual & Customary Fee Schedule for Breast & Cervical Screening & Diagnostic Services on Practice Letterhead	
Are your services billed for global, technical or Professional fee? Select one. ***If selected codes are billed differently, please indicate which codes are global, technical or professional on the copy of your fee schedule.***	□ Global □ Technical □ Professional □ Mixture – see notations on fee schedule
Are services and facilities accessible to the disabled?	□ Yes □ No □ Other (explain)

Questions regarding this checklist, requested documents and any other document contained in the contract package should be directed to your Area Screening Coordinator (see attached Screening Coordinator List). Thank you in advance for completing all required paperwork and for participating in the ABC program.

Breast & Cervical CANCER EARLY DETECTION Program of Alabama

CONTRACTOR/SUB-CONTRACTOR'S FORM

Please list all entities which will be operating under your FEIN/Contract, to include the facility's name, address, telephone number and contact person's name.

_____

FEIN

NAME OF FACILITY	ADDRESS	TELEPHONE #	CONTACT PERSON

Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP)
FY12 Reimbursement Rate Table
(Effective for Dates of Service Beginning June 30, 2011 to June 29, 2012)

Current Procedural Terminology (CPT) Description	Procedure Code	Reimbursement rate	Professional (26)	Technical (TC)
Office Visits - New Patients				
New Patient Screening (Pap Smear, Pelvic Exam AND Clinical Breast Exam) does not include Pap smear lab fee	**99203**	**$96.90**		
New Patient Partial Screening (Pap Smear and Pelvic or Clinical Breast Exam) does not include Pap lab fee	**99202**	**$67.12**		
Office Visits - Established Patients				
Established Patient Annual Screening (Pap Smear, Pelvic Exam AND Clinical Breast Exam) does not include Pap Smear Cytology lab fee	**99213**	**$65.32**		
Established Partial Screening (Pap Smear and Pelvic Exam or Clinical Breast Exam) does not include Pap smear lab fee	**99212**	**$39.04**		
Referral patient (ex: referral for mamm from other provider) or established - 5 minutes	**99211**	**$18.58**		
Consultations				
Consultation Visit - 10 minutes face-to-face with patient	**99201**	**$38.72**		
Consultation Visit - 20 minutes face-to-face with patient	**99202**	**$67.12**		
Consultation Visit - 30 minutes face-to-face with patient	**99203**	**$96.90**		
Breast Screening and Diagnostic Procedures **Screening**				
Screening Mammogram	**77057**	**$76.32**	**$33.58**	**$42.73**
Screening Mammogram, digital image	**G0202**	**$76.32**	**$33.58**	**$42.73**
Diagnostic				
Diagnostic Unilateral Mammogram	**77055**	**$81.36**	**$33.58**	**$47.77**
Diagnostic Unilateral Mammogram, digital image	**G0206**	**$81.36**	**$33.58**	**$47.77**
Diagnostic Bilateral Mammogram	**77056**	**$104.01**	**$41.73**	**$62.28**
Diagnostic Bilateral Mammogram, digital image	**G0204**	**$104.01**	**$41.73**	**$62.28**
Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation	**77031**	**$152.01**	**$76.49**	**$75.52**
Preoperative placement of needle localization wire, breast, radiological supervision and interpretation	**77032**	**$52.79**	**$26.77**	**$26.02**
Radiological examination, surgical specimen	**76098**	**$18.06**	**$7.81**	**$10.25**
Ultrasound, Global-Echography, Breasts (unilateral or bilateral) B-scan and/or real time with image documentation	**76645**	**$83.49**	**$25.94**	**$57.55**
Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	**76942**	**$184.71**	**$32.25**	**$152.45**
Aspiration of Cyst of Breast	**19000**	**$101.29**		
Puncture aspiration of each additional cyst of breast	**19001**	**$24.87**		
Biopsy of breast; needle core (surgical procedure only)	**19100**	**$130.98**		
Incisional biopsy of breast	**19101**	**$298.28**		
Biopsy of breast, percutaneous, needle core, using imaging guidance	**19102**	**$198.95**		
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	**19103**	**$509.11**		
Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion, or nipple lesion (surgical professional fee)	**19120**	**$430.43**		
Excision of breast lesion identified by pre-operative placement of radiological marker-single lesion	**19125**	**$477.67**		
Excision of breast lesion identified by pre-operative placement of radiological marker-each additional lesion	**19126**	**$146.49**		
Preoperative placement of needle localization wire, breast	**19290**	**$149.17**		
Preoperative placement of needle localization wire, breast, each additional lesion	**19291**	**$63.53**		
Image guided placement, metallic localization clip, percutaneous, during breast biopsy	**19295**	**$83.72**		
Fine Needle Aspiration without imaging guidance	**10021**	**$131.90**		
Fine Needle Aspiration with imaging guidance	**10022**	**$127.75**		
Breast Lab				
Laboratory Evaluation of Fine Needle Aspiration	**88172**	**$48.15**		
Interpretation and Report of Fine Needle Aspiration	**88173**	**$130.34**		
Breast biopsy interpretation	**88305**	**$99.91**		
Level V-Surgical pathology, breast biopsy interpretation	**88307**	**$213.13**		
Pathology consultation during surgery, first tissue block, with frozen section	**88331**	**$87.43**		

Cervical Screening and Diagnostic Procedures				
Lab fee for Pap test (Conventional); manual screening under physician supervision	**88164**	**$14.87**		
Lab fee for Pap test (Conventional/LBC); requiring interpretation by physician	**88141**	**$27.38**		
Lab fee for Pap test (LBC); manual screening under physician supervision	**88142**	**$28.51**		
Lab fee for Pap test (LBC); manual screening and rescreening under physician supervision	**88143**	**$28.51**		
Lab fee for Pap test (LBC); screening by automated system, under physician supervision	**88174**	**$28.51**		
Lab fee for Pap test (LBC); screening by automated system and manual rescreening, under	**88175**	**$28.51**		
HPV test	**87621**	**$31.72**		
Diagnostic				
Colposcopy without Biopsy (surgical procedure only)	**57452**	**$101.26**		
Colposcopy with Biopsy and endocervical curettage (surgical procedure only)	**57454**	**$143.43**		
Colposcopy with biopsy(s) of the cervix	**57455**	**$133.26**		
Colposcopy with endocervical curettage	**57456**	**$125.97**		
Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	**58110**	**$45.16**		
Endometrial sampling (biopsy) with or w/o endocervical sampling	**58100**	**$102.29**		
Endoscopy with loop electrode biopsy(s) of the cervix	**57460**	**$271.16**		
Endoscopy with loop electrode conization of the cervix	**57461**	**$305.02**		
Cervical Biopsy, single or multiple	**57500**	**$121.31**		
Endocervical curettage(not done as a part of a d&c)	**57505**	**$94.80**		
Conization of cervix; cold knife or laser	**57520**	**$285.46**		
Loop electrode excision procedure	**57522**	**$246.04**		
Colposcopy Biopsy Interpretation	**88305**	**$99.91**	**$35.42**	**$64.49**

ANESTHESIA For BREAST BIOPSY				
ABCCEDP Policy is to pay Base Rate, i.e., 3 units plus number of 15 minute billed units. If MD and CRNA both bill, each is allowed half unit cost. Maximum of 9 Global Rates.				
		Global	**M.D.**	**CRNA**
Base Anesthesia Rate	**00400 Base**	**$59.64**	**$29.82**	**$29.82**
One 15 Minute Unit	**400**	**$19.88**	**$9.94**	**$9.94**

Note: 1) Procedures not listed in this table are not covered by ABCCEDP.

2) Providers need to discuss any non-covered services with clients before providing them.

Reimbursement Policy for Treatment-related services: ABCCEDP cannot and will not pay for any treatment-related services.

Reimbursement Policy for HPV testing: Digene HPV test or Cervista HPV HR Test (paid at Digene HPV test rate); Not reimbursable as primary screening t
Only reimbrusable after ASCUS Pap or one year surveillance from LGSIL Pap with no CIN2, 3 on Colpo directed biopsy.

Date: 01/11/2011

STATE OF ALABAMA DEPARTMENT OF

PUBLIC HEALTH

Donald E. Williamson, MD
State Health Officer

August 4, 2011

The Honorable Robert Bentley, Governor
State of Alabama
State Capitol
Montgomery, Alabama 36104

The Honorable Bill Holtzclaw, Chairman
Legislative Oversight Review Committee
Alabama State House
11 S. Union Street
Montgomery, Alabama 36104

Dear Governor Bentley
Mr. Chairman:

RE: Blanket Approval Professional and Personal Service Form Contracts Renewal Contract List attached

The attached list of form contracts is being submitted for approval and to be renewed as for an additional two years from the date of this letter.

In an effort to streamline the contract review process of routine and non controversial contracts, and to avoid as much redundant and unnecessary review as possible, so that the contracts in question can be entered into in an expeditious manner and services provided rapidly, I hereby request on behalf of Dr. Williamson and the State Health Department blanket approval and exemption from review from your respective offices for the contracts listed below with copy enclosed.

These contracts are form contracts with standard pay scale amounts and are for the performance of health care services. The purpose of these contracts is to provide health care services to the eligible population of the State and is exempt from Act. No. 2001-956 per Section 11.

With your approval, I would propose that these contracts bypass your offices. The Governor's signature line and the signature line for the Chairman of this Committee, or the Chairman's acting authority, on this letter would indicate that blanket authorization has been granted. Each contract would have a copy of this letter attached to it prior to being sent to the Comptroller for payment. We would further propose that the Comptroller accept this letter in lieu of the Governor's signature and Committee stamp on each contract.

Your early consideration and approval of this request will facilitate the contracting process for the Department and save contract review time for those contracts which are not standard form contracts. I will be glad to discuss this matter with you at your request.

Yours very truly,

Patricia E. Ivie
General Counsel

PEI/ct
Enclosures:
cc: Donald E. Williamson, State Health Officer
Reuben E. Davidson, Director, Health Financial Services
Thomas L. White, State Comptroller
Sandra Collins/Sajjan Rajendra, Directors, Accounting Division, Health Financial Services

ACCEPTED AND APPROVED:

Robert Bentley, Governor
Date: 9/4/2011

Bill Holtzclaw, Chairman
Date: 8-4-2011