



Utah State Department of Health  
BUREAU OF HEALTH PROMOTION  
P.O. Box 142107  
Salt Lake City, Utah 84114-2107  
Telephone: (801) 538-6712 or 1-800-717-1811  
Fax: (801) 237-0775

**BeWise  
Laboratory Services Agreement**

Lab Name: \_\_\_\_\_

Office Hours: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (Zip) (County)

Fax Number \_\_\_\_\_ Telephone: \_\_\_\_\_

Contact Person: \_\_\_\_\_ NPI# \_\_\_\_\_

The purpose of the BeWise Program is to expand preventive health care services to women who receive breast and cervical cancer screening through the Utah Cancer Control Program. In addition to breast and cervical cancer screening eligible women receive a blood glucose test, lipid panel, blood pressure screening, and lifestyle coaching.

This facility/lab agrees to participate in the **BeWise Program** within the Utah Department of Health (UDOH) and to provide lab work services at the stated reimbursement to women who present with a BeWise Lab Requisition order form referred by a BeWise contracted provider.

The service period for this agreement will be ongoing from \_\_/\_\_/\_\_\_\_ (DATE) unless terminated or extended by agreement in accordance with the terms and conditions of this Provider Agreement.

**A. Allowable CPT Codes and Reimbursement Rates.**

*The BeWise Program will **ONLY** reimburse the facility/lab for the following labs services:*

CPT	DESCRIPTION	UCCP RATE
80061	Lipid Panel	\$16.53
82465	Cholesterol, total	\$5.37
83718	HDL cholesterol	\$10.12
82947	Glucose; quantitative	\$4.85
82948	Glucose; blood, reagent strip	\$5.04
82951	Glucose tolerance test, three specimens	\$15.89
83036	Hemoglobin, glycated (HbA1c) <i>used in lieu of other glucose testing for those with previous diagnosis of diabetes</i>	\$11.99
80048	Basic Metabolic profile	\$10.44
80053	Comprehensive metabolic panel	\$13.04
36415	Routine venipuncture	\$3.00

**B. Lab requirements**

*For the period of this agreement, the Facility/lab must:*

1. Hold CLIA licensure
2. Hold all required state licenses
3. Meet Medicare program requirements
4. Are accredited by the College of American Pathologists (CAP), the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), or state laboratory inspection programs.

**C. Timely reporting of results**

1. All blood tests must be reported to the BeWise Program and the referral clinic within five (5) business days of the initial drawn.

**D. Reimbursement**

1. The laboratory will bill the BeWise Program only for the services above indicated (CPT included) If other *tests* are required these are the responsibility of the client.
2. The Laboratory must accept State Medicare Reimbursement rates as payment in full for the above lab services indicated.
3. The laboratory is prohibited from billing patients for any additional charges for lab interpretation.
4. The laboratory will bill insurance carrier if clients has listed insurance information. Reimbursement from the BeWise Program shall be sought only after other insurance reimbursement available to the patient is exhausted.
5. Reimbursement is contingent upon receipt of a copy of lab results.
6. Only one fee (unit price) will be charged per specimen; no additional fee can be charged such as for re-examination of abnormal specimen by pathologist.
7. Payment for the above listed services will be billed to the BeWise Program at the following address:  
 BeWise Program  
 PO Box 142107,  
 Salt Lake City, Utah, 84114-2107
8. Each bill should include the provider's name/facility name, address, patient's name, date of birth, the service provided, the date of service, the cost for each service, and the amount that is due
9. The BeWise Program shall pay claims submitted by the laboratory based on agreed rate within thirty (30) days from the submission of a claim, subject to paragraph C 4 above. The BeWise Program will reimburse any unpaid amount remaining after the insurance has been billed up to the amount set forth in paragraph "A" Above.

**E. Special Provisions:**

1. This agreement may be ended by the Facility/Laboratory or the BeWise Program at any time with 30 days written notice from either the provider or the UDOH. In the event of a termination of the agreement, the BeWise Program will reimburse the Provider for costs incurred to the date of termination.
2. The agreed facility shall contact the BeWise Program Director immediately if the provider is unable to fulfill any of the requirements of the agreement or if there are any questions regarding the interoperations of the provisions of the agreement.
3. Each of the parties represents and warrants to the other party that it will comply with all applicable laws, rules, and regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, the HIPAA standard transactions and security regulations (as of the effective dates of those regulations).
4. In acknowledgement of the aforementioned, these authorized representatives of the Provider Agreement and the BeWise Program do hereby indicate their consent.

\_\_\_\_\_  
Name (printed or typed)

\_\_\_\_\_  
Signature of the Facility Agreement Monitor

\_\_\_\_\_  
Business Address (printed or typed)

\_\_\_\_\_  
Business Telephone (printed or typed)

\_\_\_\_\_  
Date

**Important Contact Persons**

BeWise Program Manager: Kalynn Filion 801-538-7009

BeWise RN Clinical Services Coordinator: Anna Testa 801-538-6437

Contracts and Agreements: Joannah Sparks 801-538-9271

Accounting and Billing: Lily Doyle 801-538-6230