Florida Breast and Cervical Cancer Early Detection Program (FBCC) Provider Form

FBCCEDP Region: _____

Date: _____

Regional Coordinator: _____

Please fill out the information below.

Provider Name: _____

Mailing Address: _____

City: _____

County: _____

State: _____

Zip Code: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Services Provided: ☐ **Breast** ☐ **Cervical** ☐ **Mammogram** ☐ **Other (Surgery, biopsy, etc.)**

Federally Qualified Health Center (FQHC): ☐ **Yes** ☐ **No**

Mammovan: ☐ **Yes** ☐ **No**

Fee Schedule: ☐ **Global** ☐ **Professional** ☐ **Technical**

Comments:

For Central Office Use Only

Assigned Provider Number: