FREQUENTLY ASKED QUESTIONS

I already had my appointment but didn’t know about the screening program. Can you still cover my appointments and procedures?

The preferable process is to be enrolled in the screening program before you attend the appointments. However, if you are eligible for the program at the time of service, we may be able to back-date your application and provide coverage. Please contact us for more information if this is your situation.

My high-deductible insurance paid for my screening mammogram, but now the hospital wants me to come back for another mammogram and an ultrasound. My insurance won’t cover those additional procedures, and I can’t afford to pay. I just found out about the screening program, can you still help?

Insurance plans are required to pay for certain wellness procedures, including breast and cervical cancer screenings. However, if you have an abnormal result that requires additional screenings, your insurance might not cover it and you will be responsible for the bill. But again, call us because if you qualify (age, income, and a deductible over $500) we still may be able to help.

I thought mammograms and PAP tests were supposed to be every year? Why are you making me wait?

There are several different guidelines for screening intervals, especially for mammograms. The guidelines that we follow are from the US Preventative Services Task Force and state that “if everything is normal, women should start getting mammograms at age 50 and have one every other year. Women should start having Pap tests at age 21 and have on every three years. At age 30, you can choose to have a Pap test and an HPV test at the same time.” If the final outcome of both procedures is negative, you do not need another screening for another 5 years.

Of course, your family and personal health histories can affect how often you should be screened for breast and cervical cancer. It is important to talk to your medical provider to determine the best age for you to start Paps and/or mammograms and how often to have these screenings. If your provider says that you need a mammogram every year, because of a family history of breast cancer or a person history of certain exposure, you can be covered for a mammogram every year.

I’ve been in your program before. Why do I have to fill out another enrollment form?

We require a new enrollment form every time you need your screenings. If you had a mammogram covered through our program two years ago, we will need to re-enroll for future services. The re-enrollment process allows us to update your personal information.

If you need additional services along with the breast exam, mammogram or Pap, (such as another mammogram, ultrasound, etc.) you will not need to re-enroll since those services are essentially part of the original exam.

I had a breast exam, mammogram and Pap test last year, but I’m experiencing some problems that I’m not sure about. Can I get another procedure done even if my last one came back normal?

If you are having problems or are experiencing symptoms that you’re not used to, we can cover another procedure before you were originally due.
I had my mammogram and the hospital called me back for additional imaging. Will you pay for another mammogram, ultrasound or biopsy?

Yes. If you are called back for more diagnostic imaging, we will provide coverage for certain procedures until breast cancer is either diagnosed or ruled out. Once caner is ruled out, the program will not pay for any other services.

I had my Pap and my provider recommended I have a pelvic ultrasound. Why won’t you cover it?

It’s simple! We do **cervical** screenings. If you have a problem or issue that is directly related to your cervix we will cover it. Pelvic ultrasounds are more often used to look at the uterus and ovaries, which are not covered and are not the focus of our program.

My provider said I need a colposcopy. Will that be covered?

Your provider might recommend a colposcopy. This is a procedure that we can cover. During a colposcopy, your provider is looking at your cervix and can biopsy areas of the cervix that look suspicious for change. Please call us and let us know if your provider has recommended a colposcopy or has scheduled one for you.

I was diagnosed with breast or cervical cancer. What happens now?

If you are screened through our program and diagnosed with breast or cervical cancer, we will connect you to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP), which is a version of Medicaid. Coverage will continue for the duration of your cancer treatment. However, if you qualified for our program based solely on your **high-deductible insurance plan**, you are not eligible for the MBCCTP. This special Medicaid program is available only to women who were screened through our program and who have no other creditable insurance. Stay in close contact with us so we can facilitate this transition. Once coverage is approved, it will backdate to the beginning of the month during which you were diagnosed so there will be no gap in coverage.

I received a statement from the provider. I thought that this program was supposed to be free? I can’t pay this and it’s going to be sent to collections.

Sometimes a provider’s office will have a change in billing staff. So, if you receive a bill, please contact our office (406-751-8162) immediately so we make sure the bill gets paid correctly.

If you have any other questions related to the Montana Cancer Screening Program or related to breast and cervical cancer and screening guidelines, please do not hesitate to call us: 406-751-8162, 406-751-8163 or 406-751-8226