ScreenWise Billing Contact Information

(Please keep us informed of any contact changes)

Date: _____

Organization: _____ **Site Name:** _____

Manager/Administrator: (Primary point of contact for ScreenWise Breast and Cervical Cancer Screening)

Full Name: _____ Title/Position: _____

Direct Phone & Ext.: _____

E-mail: _____

Billing Contact Person:

Full Name: _____ Title/Position: _____

Direct Phone & Ext.: _____

E-mail: _____

EOB (Explanation of Benefits) Contact Person:

Full Name: _____ Title/Position: _____

Direct Phone & Ext.: _____

E-mail: _____

Please FAX completed form to: **971-673-0997**
Or email to: **screenwise.info@odhsoha.oregon.gov**

FOR SCREENWISE/BCC OFFICE USE ONLY:

ORG #		SITE #1	
CONTACTS #		SITE #2	
CONTACTS #		SITE #3	
CONTACTS #		SITE #4	
FIPS		SITE #5	
MAIL CODE		SITE #6	

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