



Breast Imaging Center of Excellence Request

In order to be eligible for the ACR's Breast Imaging Center of Excellence (BICOE) designation, a center must be accredited in:

- Mammography (by the ACR or an FDA-approved state accrediting body), and
- Stereotactic breast biopsy (by the ACR), and
- Breast ultrasound and Ultrasound-guided breast biopsy (by the ACR)

The owner/officer and lead interpreting physician must sign the request for each affiliated facility. Please copy form for additional facilities.

Reason for requesting ACR designation as a Breast Imaging Center of Excellence:

- Our mammography facility is accredited by Arkansas, Iowa or Texas. (*You must send a copy of your current MQSA certificate.*)
- Our center is currently accredited in all required breast imaging modalities but under different names.
- Our center has affiliated accredited facilities at different physical locations. (*These facilities must be fully accredited in all breast imaging services provided to be considered part of the Breast Imaging Center of Excellence. With appropriate verification, the ACR will recognize the facility as an affiliate of a Breast Imaging Center of Excellence. Affiliates must designate one of their ACR-accredited facilities as their center's "home facility" for the ACR to use as a point of contact. The ACR will notify the center's home facility of its approval via letter.*)

List all of the center's accredited breast imaging facilities:

Name of Breast Imaging Location	Services Provided at this Location	Accredited By	ACR (or State) ID #
Name: Center's Home Facility <input type="checkbox"/> BICOE certificate sent to home facility at no charge	<input type="checkbox"/> Mammography	ACR AR IA TX <small>(circle one)</small>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
Required: Print Name _____ Signature _____ Officer or Owner: _____ Lead Interpreting Physician: _____			
Name: Affiliated by: <input type="checkbox"/> Same ownership <input type="checkbox"/> Same radiology group <input type="checkbox"/> Other (please provide letter of explanation) <input type="checkbox"/> Request BICOE certificate for this location (\$50 each)	<input type="checkbox"/> Mammography	ACR AR IA TX <small>(circle one)</small>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
Required: Print Name _____ Signature _____ Officer or Owner: _____ Lead Interpreting Physician: _____			
Name: Affiliated by: <input type="checkbox"/> Same ownership <input type="checkbox"/> Same radiology group <input type="checkbox"/> Other (please provide letter of explanation) <input type="checkbox"/> Request BICOE certificate for this location (\$50 each)	<input type="checkbox"/> Mammography	ACR AR IA TX <small>(circle one)</small>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
Required: Print Name _____ Signature _____ Officer or Owner: _____ Lead Interpreting Physician: _____			

_____ person completing this form

_____ phone number

_____ date

Please fax this form to (703) 648-9176. If you have any questions, call the Breast Imaging Accreditation Information Line at (800) 227-6440.