



1891 Preston White Drive, Reston, VA 20191-4397

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) **and**
- **Breast MR** (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"/> Mammography	ACR AR IA TX <i>(circle one)</i>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
	<input checked="" type="checkbox"/> BICOE certificate sent to home facility at no charge	<input type="checkbox"/> Breast MRI	ACR
Required: Officer or Owner: _____ Lead Interpreting Physician: _____		Print Name _____ Signature _____	
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 <i>(circle one)</i>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
	<input type="checkbox"/> Breast MRI	ACR	BMRAP:
Required: Officer or Owner: _____ Lead Interpreting Physician: _____		Print Name _____ Signature _____	
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 <i>(circle one)</i>	MAP/State:
	<input type="checkbox"/> Stereotactic Breast Biopsy	ACR	SBBAP:
	<input type="checkbox"/> Breast Ultrasound	ACR	BUAP:
	<input type="checkbox"/> Ultrasound-Guided Breast Biopsy		
	<input type="checkbox"/> Breast MRI	ACR	BMRAP:
Required: Officer or Owner: _____ Lead Interpreting Physician: _____		Print Name _____ Signature _____	

person completing this form email phone number date

Please email this form to bicoe@acr.org or fax it to (703) 648-9176. If you have any questions, please email BICOE@acr.org