

RECERTIFICATION

Breast and Cervical Cancer Medicaid

APPLICATION FOR CONTINUING BCCM ELIGIBILITY

Re-certification is required for BCCM coverage beyond the original approval period, or treatment beyond 12 months. Routine breast and /or cervical re-screening should be performed through the BCCCP provider.

BCCCP Coordinator: By checking (✓) YES you are verifying patient eligibility for BCCM

Yes

This patient is enrolled in the NC Breast and Cancer Control Program (BCCCP), and has received screening and/or diagnostic testing per the BCCCP guidelines.

(A ✓ by YES requires this form be completed by the diagnosing or treating physician.)

Name of Medical Clinic responsible for diagnosis and treatment plan:		Phone: ()
Patient Name:	DOB: / /	SSN: - -
Patient Address:	CNDS/MID#:	
	Original Diagnosis Date: / /	
Diagnosis:	Stage: (if known)	
Plan for Continuation of Treatment: Please give the estimated date or number of weeks or months until aggressive treatment will end in the space provided below.		
Maintenance drugs and therapies (including hormonal treatment) are NOT covered by BCCM.		
The above treatment began/will begin on: (date)		
And continue for:		

Physician Signature

Date

Patient County of Residence:	BCCCP Provider:	
BCCCP Coordinator:	Phone:	
DSS Representative:	Date:	
DSS Phone:	DSS FAX:	
Determination	Date of Determination	Nurse Consultant Signature
<input type="checkbox"/> Approved for _____ months		
<input type="checkbox"/> Denied - Reason:		

THIS IS A REQUIRED ATTACHMENT TO THE APPLICATION FOR BREAST & CERVICAL CANCER MEDICAID (BCCM)