

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

<input type="checkbox"/> 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.)
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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.		
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)