

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: Please check (√) YES or NO:	
<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.)
<input type="checkbox"/> No	This patient is NOT a participant of BCCCP and has not received screening and/or diagnostic testing per BCCCP guidelines to receive this diagnosis. (A √ by NO is an indication that the patient is not a candidate for the BCCM. Please call your BCCCP Case Manager for more information.)

Name of Medical Clinic responsible for diagnosis and treatment plan:		Phone: ()
Patient Name:	DOB: / /	SS#: - -
Patient Address:	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:

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

Determination	Date of Determination	Nurse Consultant Signature
<input type="checkbox"/> Approved for ____ months		
<input type="checkbox"/> Denied - Reason:		