VERIFICATION OF SCREENING, DIAGNOSIS, AND TREATMENT

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

Yes ☐	This patient meets eligibility requirements for the NC Breast and Cervical Cancer Control Program (BCCCP). The patient has received screening and/or diagnostic testing per the NC BCCCP guidelines. ☐ Diagnosed in NC BCCCP **OR** ☐ Diagnosed outside NC BCCCP

Additional certification is required for BCCM coverage to extend beyond the original certification period or beyond 12 months.

Name of Medical Clinic responsible for diagnosis and treatment plan:		**Phone:**
Patient Name:	**DOB:**	**SSN:**
Patient Address:		**CNDS/MID#:**
Diagnosis:	**Stage: (if known)**	**Diagnosis Date:**

Diagnosis Confirmed by: (Pending or unconfirmed diagnoses will result in BCCM denial)
☐ **Colposcopy** ☐ **Biopsy** ☐ **Other:**

Treatment Plan: Please describe the **specific** treatment plan, the date the treatment will begin and duration of treatment (the number of weeks or months of anticipated treatment) in the space provided below:

Treatment to begin (date)_____

and continue for: _____
(# of weeks or months of anticipated treatment)

Physician Signature **Date**

Patient County of Residence:	**BCCCP Provider:**
BCCCP Coordinator:	**Phone:**
DSS Representative:	**Date:**
DSS Phone:	**DSS FAX:**
DSS Caseworker Email:	

Determination	Date of Determination	Nurse Consultant Signature
☐ **Approved for_____months**		
☐ **Denied - Reason:**		

Notes:

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