

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 describe the specific treatment plan, the date the treatment began and duration of treatment (the number of weeks or months until treatment will end) in the space provided below:		
The above treatment will begin/began on: (date)		
And continue for (number 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
<input type="checkbox"/> Approved for ____ months		
<input type="checkbox"/> Denied - Reason:		
Notes:		

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