

# 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.)

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

**Physician Signature**

**Date**

<b>Patient County of Residence:</b>	<b>BCCCP Provider:</b>
<b>BCCCP Coordinator:</b>	<b>Phone:</b>
<b>DSS Representative:</b>	<b>Date:</b>
<b>DSS Phone:</b>	<b>DSS FAX:</b>

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:		