# 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.**<br>(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 give the estimated date or number of weeks or months until 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** |
|---|---|---|
| ☐ **Approved for ____months** | | |
| ☐ **Denied - Reason:** | | |

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