VERIFICATION OF SCREENING, DIAGNOSIS, AND TREATMENT						
BCCCP Coordinator: By checking (✓) YES you are verifying patient eligibility for BCCM						
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 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: CND				CNDS/MII	D#:	
Diagnosis: Stage			e: (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:						
and continue for:						
Physician Signature				Date		
Patient County of Residence:			BCCCP Provider:			
BCCCP Coordinator:			Phone:			
DSS Representative:			Date:			
DSS Phone: DSS FAX: DSS Caseworker Email:						
DOU CASEWOINGI LIIIAII.						
Determination	Date of Determination	Nurco Concultar		ultant Signa	ature	
Approved formonths						
☐ Denied - Reason:						
Notes:						

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

DHB-5081 Revised 3/2024