VERIFICATION OF SCREENING, DIAGNOSIS AND TREATMENT

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 to be completed by the diagnosing or treating physician.)

Additional certification is required for BCCM coverage to extend beyond the original certification period or beyond 12 months. Routine breast and /or cervical re-screening should be performed through the BCCCP provider.

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 (describe)**:**

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:**

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)