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 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)