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 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 **OR** ☐ Diagnosed outside of NC BCCCP

(A check 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)