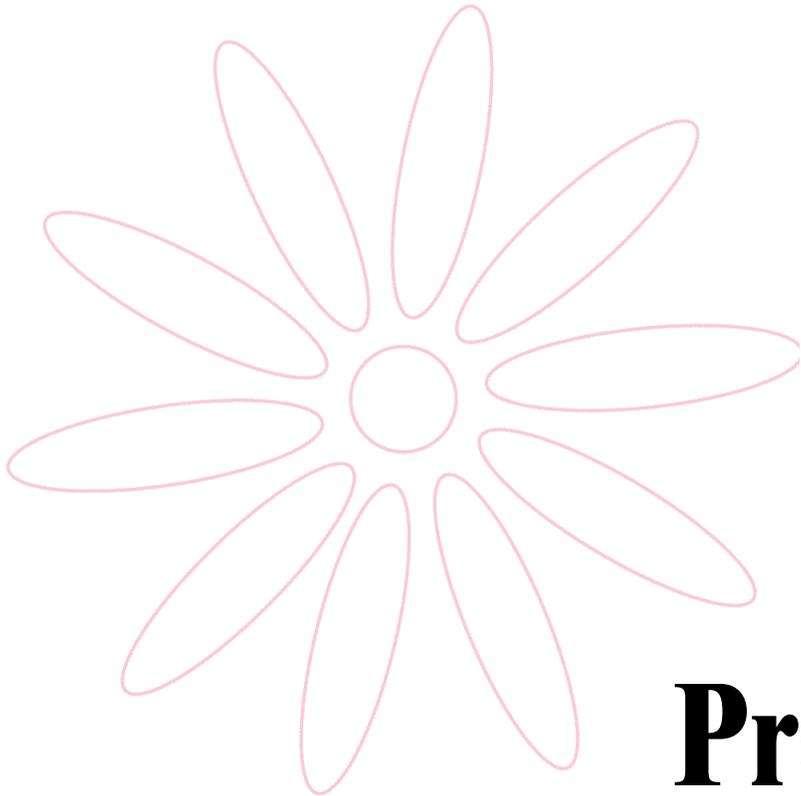


Breast & Cervical Cancer

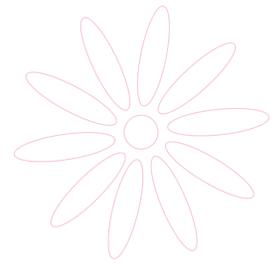


Prevention & Treatment Program

**ANNUAL
RENEWAL**

PA 600BR

Breast and Cervical Cancer Prevention and Treatment Program



Instructions for Completing Form PA 600 BR Annual Renewal Form

PART I – TO BE COMPLETED BY THE APPLICANT OR APPLICANT'S REPRESENTATIVE

YOUR NAME: Last, First, Middle Initial – Print or type clearly the Last Name, First Name and Middle Initial of the recipient.

DATE OF BIRTH: Enter the eight-digit birth date (mm/dd/yyyy) of the recipient.

SOCIAL SECURITY NUMBER: Enter the nine-digit social security number of recipient.

PART II – TO BE COMPLETED BY A PROVIDER

CONTINUED TREATMENT REQUIRED FOR: Check the appropriate box to indicate the recipient's condition requiring continued treatment.

ADDITIONAL ELIGIBILITY PERIOD REQUESTED: Check the appropriate box to indicate the requested extension of eligibility. The requested eligibility should be based on the expected length of treatment, not to exceed 12 months.

REQUIRED DOCUMENTATION: Check the boxes to indicate that all required documentation is included in the submission.
NOTE: Treatment for breast or cervical cancer, as defined, will be used by the physician reviewer in the approval/denial of additional eligibility periods.

PROVIDER NAME: Enter the name of the provider who renders medical care to the recipient.

PROVIDER M.A.I.D. NUMBER: If the provider is a Medical Assistance (MA) participating provider, enter the seven-digit Medical Assistance Provider ID number assigned to the designated payee. If the provider is not an MA provider, leave the field blank.

TELEPHONE NUMBER: Enter the telephone number of the office where the recipient is seen.

ADDRESS – STREET, CITY, STATE: Enter the address of the office where the recipient is seen.

PROVIDER AUTHORIZED SIGNATURE AND DATE: Signature of the provider who renders medical care to the recipient and the date the form is completed.

NOTE: This signature attests to the fact that all information indicated in Part II is complete and accurate.

The provider must fax (717-772-6179) or mail the renewal form back to the Office of Medical Assistance Programs at: Department of Public Welfare, Office of Medical Assistance Programs, Division of Medical Review/BCCPT, PO Box 8171, Harrisburg, PA 17105.

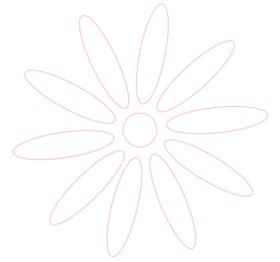
PART III – TO BE COMPLETED BY OMAP (PHYSICIAN REVIEWER)

PART IV – TO BE COMPLETED BY COUNTY ASSISTANCE OFFICE

Commonwealth of Pennsylvania
Department of Public Welfare

Breast and Cervical Cancer Prevention and Treatment Program

ANNUAL RENEWAL



COUNTY NO.	RECORD NO.	CATEGORY	LINE NO.
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PART I. CLIENT INFORMATION

YOUR NAME – Last, First, Middle Initial	DATE OF BIRTH	SOCIAL SECURITY NO.	
ADDRESS	STATE	ZIP CODE	TELEPHONE ()

COMPLETE THE FOLLOWING INFORMATION AND SIGN BELOW

YES NO DO YOU HAVE HEALTH INSURANCE? IF YES, PROVIDE THE FOLLOWING INFORMATION:

Name of Insurance Carrier:	POLICY NO.	GROUP NO.
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RIGHTS AND RESPONSIBILITIES

- I understand that the information on this form will be kept confidential.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of Medicaid program.
- I understand that I must report any change in my circumstances that may affect my eligibility to the County Assistance Office within one week.
- I understand that I may request a hearing if I do not agree with a decision made on this application.
- I understand that all Medicaid applicants/recipients must provide their Social Security Number. This number may be used to check on information on this application.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group plan that has a pre-existing condition, I may get credit for the time I received Medicaid.
- I certify that the information on this application is correct under penalty of perjury.
- I certify that I understand my rights and responsibilities.

CLIENT'S SIGNATURE

DATE

CLIENT'S COMMENTS: _____

**Please take this form to your doctor or medical provider as soon as possible.
This form needs to be completed and signed by a doctor or medical provider.**

PART II. TO BE COMPLETED BY PROVIDER

INDIVIDUAL'S TREATMENT IS FOR:

1. BREAST CANCER CERVICAL CANCER PRE CANCEROUS CONDITION

ADDITIONAL ELIGIBILITY PERIOD REQUIRED:

2. 3 MONTHS 6 MONTHS 12 MONTHS NO LONGER NEEDS TREATMENT

3. REQUIRED DOCUMENTATION FOR CONSIDERATION OF CONTINUED ELIGIBILITY

- Copies of diagnostic and pathology test results/reports pertaining to the diagnosis of breast or cervical cancer.
- A letter from the treating physician documenting medical necessity for further treatment of breast or cervical cancer, which includes:
- Current cancer diagnosis, including stage and ICD-9 code.
 - A detailed summary of breast or cervical cancer treatment and the applicant's response, including a statement of applicant's compliance with cancer treatment to date.
 - Anticipated plan of care, including expected course and length of treatment.

NOTE: Applicant must require treatment for a current diagnosis of breast or cervical cancer. Treatment for breast or cervical cancer is defined as medical services which are, or are reasonably expected to:

- Ameliorate the direct effects of the breast or cervical cancer; or
- Aid in the clinical characterization of the breast or cervical cancer, including test or cure, but excluding screening for recurrence or new primary cancer; or
- Prevent the recurrence of breast or cervical cancer.

PROVIDERS NAME

PROVIDER M.A.I.D. NUMBER

TELEPHONE NUMBER

ADDRESS

STATE

ZIP CODE

PROVIDER AUTHORIZED SIGNATURE

DATE

**Please fax (717) 772-6179 or mail this application back to the Office of Medical Assistance Programs at:
PROVIDER: Department of Public Welfare, Office of Medical Assistance Programs, Division of Medical Review/
BCCPT, PO Box 8171, Harrisburg, PA 17105**

PART III. TO BE COMPLETED BY OFFICE OF MEDICAL ASSISTANCE PROGRAMS

ADDITIONAL ELIGIBILITY PERIOD APPROVED 3 MONTHS 6 MONTHS 12 MONTHS ICD.9 CODE _____

INDIVIDUAL NO LONGER NEEDS TREATMENT UNDER THE BCCPT PROGRAM BASED UPON THE MEDICAL EVALUATION.

NAME

OFFICE

TELEPHONE NUMBER

OMAP AUTHORIZED SIGNATURE

DATE

PART IV. TO BE COMPLETED BY COUNTY ASSISTANCE OFFICE

INDIVIDUAL REMAINS ELIGIBLE FOR ONGOING MEDICAID UNDER THE BCCPT PROGRAM.

INDIVIDUAL IS NO LONGER ELIGIBLE FOR ONGOING MEDICAID UNDER THE BCCPT PROGRAM BECAUSE:

MEDICAL EVALUATION AS NOTED IN PART III CREDITABLE INSURANCE COVERAGE AGE (OVER 65)

CAO WORKER'S SIGNATURE

DATE