Breast and Cervical Cancer Prevention and Treatment Program

RENEWAL

Breast and Cervical Cancer Prevention and Treatment Program

Instructions for Completing Form PA 600 BR Renewal Form

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

PRINT or TYPE clearly: Your Name, Date of Birth, Social Security Number, Address and Phone Number.

ANSWER the Health Insurance question.

READ AND SIGN the Rights and Responsibilities.

PART II – TO BE COMPLETED BY A PROVIDER

CONTINUED TREATMENT REQUIRED FOR: Check the appropriate box to indicate the applicant'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 applicant is seen.

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

PROVIDER AUTHORIZED SIGNATURE AND DATE: Signature of the provider who renders medical care to the applicant 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

RESET FIELDS

Commonwealth of Pennsylvania
Department of Public Welfare

Breast and Cervical Cancer Prevention and Treatment Program

RENEWAL

COUNTY NO.	RECORD NO.	CATEGORY	LINE NO.

PART I. APPLICANT INFORMATION

YOUR NAME – Last, First, Middle Initial				DATE OF BIRTH	SOCIAL SECURITY NO.
ADDRESS	CITY	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.

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 the State may obtain information about my circumstances from other sources, including computer matches and the U.S. Citizenship and Immigration Services except for persons applying for emergency medical assistance only.
- 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.

_____ _____
APPLICANT'S SIGNATURE DATE

ADDITIONAL INFORMATION: _____

_____

_____

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.

Applicant Name: **Applicant SSN:**

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	CITY	STATE	ZIP CODE	FAX NUMBER ( )

PROVIDER AUTHORIZED SIGNATURE DATE

PROVIDER: Please fax (717) 772-6179 or mail this application 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 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