Attachment D

COVER LETTER BCCPT ANNUAL REDETERMINATION

CAO Letterhead

(Date)

(Applicant's Name)
(Street Address)
(City, State, Zip Code)

Dear (Name)

Your Medicaid eligibility under the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program is due for an annual review by (mm/dd/yy).

Please complete and sign Part I of the enclosed form. Take the form to your doctor who is treating you for this condition and have him/her complete and sign Part II within **30** days of the receipt of this letter.

Failure to return the completed form could result in the termination of your Medicaid benefits under the Breast and Cervical Cancer Prevention and Treatment Program.

Your doctor needs to complete the form and return it to:

Department of Public Welfare
Office of Medical Assistance Programs
Division of Medical Review/BCCPT
PO Box 8050
Harrisburg, PA 17105

OR

Fax to : Medical Review/BCCPT (717) 772-6179

If you have any questions please contact me at (CAO telephone number).

Sincerely,

(CAO Caseworker's Signature)
(CAO Caseworker's Printed Name)

Enclosure