pennsylvania
DEPARTMENT OF HUMAN SERVICES

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program Medicaid Eligibility Application

Instructions for completing Form PA 600B

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

The Applicant or Applicant's representative should:

1. Print clearly or type the information in the spaces provided on the other side of this form.

2. Sign and date this form.

PART II – TO BE COMPLETED BY A PROVIDER

DATE OF DIAGNOSIS: Enter either the date of the first positive biopsy/confirmation of diagnosis, or the confirmation of reoccurrence of breast or cervical cancer.

ICD-10 CODE: Check the most appropriate box to indicate the diagnosis, and complete the diagnosis code to individually identify the condition. **Only one box should be checked.** If C77 or C79 is checked, the provider is attesting that the applicant has either breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, as a primary diagnosis. If breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, is not the primary diagnosis, applicant is not eligible for this program. **ONLY THE CODES LISTED MAY BE CHOSEN.**

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

PROVIDER MPI/NPI NUMBER: If the provider is a Medical Assistance (MA) participating provider, enter the 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 or mail the application back to the Department of Health's HealthyWoman Program Provider.

Fax: 412-201-4702
Phone: 1-800-215-7494
TTY: 1-800-332-8615

Mail: Adagio Health
960 Penn Ave., Suite 600
Pittsburgh, PA 15222

PART III – TO BE COMPLETED BY THE DEPARTMENT OF HEALTH'S HEALTHYWOMAN PROGRAM

PART IV – TO BE COMPLETED BY THE COUNTY ASSISTANCE OFFICE

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

APPLICANT'S NAME (Last, First, Middle Initial)	BIRTHDATE / /	AGE	SOCIAL SECURITY NUMBER

Marital Status ▶ ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

HOME ADDRESS (include street, apt. number, city, state, county & ZIP code+4):	PHONE NUMBER: ( )
MAILING ADDRESS (if different from home address):	SECOND PHONE NUMBER: ( )

Are you a U.S. citizen or national? ☐ Yes ☐ No

If you are not a U.S. citizen or national, answer the following questions:

Do you have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Have you lived in the U.S. since 1996? ☐ Yes ☐ No

Are you, or your spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

RACE (Optional) (Check all that apply)

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

What is your household income each month before taxes? $ _____

How many people are in your household? (Include yourself)

Do you have any children under the age of 21 living with you? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have health insurance coverage? ☐ Yes ☐ No

Have you had health insurance coverage in the last 90 days? ☐ Yes ☐ No

INSURANCE CARRIER NAME	CUSTOMER SERVICE PHONE NO.	POLICY NO.	GROUP NO.

Is the above private insurance or obtained through employment? ☐ Private ☐ Through Employment

EMPLOYER NAME	EMPLOYER TELEPHONE NO.

EMPLOYER ADDRESS

VOTER REGISTRATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

Medicaid BCCPT Program Rights and Responsibilities

- I understand that if I need treatment for breast or cervical cancer, the information on this form will be used to see if I am eligible for Medicaid.
- 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 the Medicaid program.
- I understand that I must report any change in my circumstances that may affect my eligibility to the county assistance office by the 10th day of the month following the change.
- I understand that I may request a hearing if I do not agree with the decision made on this application.
- I understand that all Medicaid applicants/recipients must provide their Social Security number, except those applying for treatment for an emergency medical condition. This number may be used to check the 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. 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 Name _____ Date ____/____/____

Applicant's Name _____ Date ____/____/____

PART II. TO BE COMPLETED BY A PROVIDER

DATE OF FIRST BIOPSY/ CONFIRMATORY DIAGNOSIS	/ /	OR	DATE OF CONFIRMATION OF REOCCURRENCE OF BREAST OR CERVICAL CANCER	/ /

ICD.10 CODE	CLINICAL DESCRIPTION	INITIAL ELIGIBILITY TIME FRAME
BREAST CANCER		
☐ **C50.** ___	**Malignant neoplasm of breast** (Includes **C50.011** - Malignant neoplasm of nipple and areola, right female breast; **C50.012** - Malignant neoplasm of nipple and areola, left female breast; **C50.019** - Malignant neoplasm of nipple and areola, unspecified female breast; **C50.111** - Malignant neoplasm of central portion of right female breast; **C50.112** - Malignant neoplasm of central portion of left female breast; **C50.119** - Malignant neoplasm of central portion of unspecified female breast; **C50.211** - Malignant neoplasm of upper-inner quadrant of right female breast; **C50.212** - Malignant neoplasm of upper-inner quadrant of left female breast; **C50.219** - Malignant neoplasm of upper-inner quadrant of unspecified female breast; **C50.311** - Malignant neoplasm of lower-inner quadrant of right female breast; **C50.312** - Malignant neoplasm of lower-inner quadrant of left female breast; **C50.319** - Malignant neoplasm of lower-inner quadrant of unspecified female breast; **C50.411** - Malignant neoplasm of upper-outer quadrant of right female breast; **C50.412** - Malignant neoplasm of upper-outer quadrant of left female breast; **C50.419** - Malignant neoplasm of upper-outer quadrant of unspecified female breast; **C50.511** - Malignant neoplasm of lower-outer quadrant of right female breast; **C50.512** - Malignant neoplasm of lower-outer quadrant of left female breast; **C50.519** - Malignant neoplasm of lower-outer quadrant of unspecified female breast; **C50.611** - Malignant neoplasm of axillary tail of right female breast; **C50.612** - Malignant neoplasm of axillary tail of left female breast; **C50.619** - Malignant neoplasm of axillary tail of unspecified female breast; **C50.811** - Malignant neoplasm of overlapping sites of right female breast; **C50.812** - Malignant neoplasm of overlapping sites of left female breast; **C50.819** - Malignant neoplasm of overlapping sites of unspecified female breast; **C50.911** - Malignant neoplasm of unspecified site of right female breast; **C50.912** - Malignant neoplasm of unspecified site of left female breast; **C50.919** - Malignant neoplasm of unspecified site of unspecified female breast.)	**12 months**
☐ **C77.** ___	**Secondary and unspecified malignant neoplasm of lymph nodes (with Breast Primary)** (Includes **C77.1** - Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes; **C77.3** - Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes; **C77.8** - Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions.)	**12 months**
☐ **C79.** ___	**Secondary malignant neoplasm of other and unspecified sites (with Breast Primary)** (Includes **C79.31** - Secondary malignant neoplasm of brain; **C79.51** - Secondary malignant neoplasm of bone; **C79.52** - Secondary malignant neoplasm of bone marrow; **C79.81** - Secondary malignant neoplasm of breast; **C79.89** - Secondary malignant neoplasm of other specified sites; **C79.9** - Secondary malignant neoplasm of unspecified site)	**12 months**
☐ **D05.** ___	**Carcinoma in situ of breast** (Includes **D05.00** - Lobular carcinoma in situ of unspecified breast; **D05.01** - Lobular carcinoma in situ of right breast; **D05.02** - Lobular carcinoma in situ of left breast; **D05.10** - Intraductal carcinoma in situ of unspecified breast; **D05.11** - Intraductal carcinoma in situ of right breast; **D05.12** - Intraductal carcinoma in situ of left breast; **D05.80** - Other specified type of carcinoma in situ of unspecified breast; **D05.81** - Other specified type of carcinoma in situ of right breast; **D05.82** - Other specified type of carcinoma in situ of left breast; **D05.90** - Unspecified type of carcinoma in situ of unspecified breast; **D05.91** - Unspecified type of carcinoma in situ of right breast; **D05.92** - Unspecified type of carcinoma in situ of left breast.)	**6 months**
CERVICAL CANCER		
☐ **C53.** ___	**Malignant neoplasm of cervix uteri** (Includes **C53.0** - Malignant neoplasm of endocervix; **C53.1** - Malignant neoplasm of exocervix; **C53.8** - Malignant neoplasm of overlapping sites of cervix uteri; **C53.9** - Malignant neoplasm of cervix uteri, unspecified.)	**12 months**
☐ **C77.** ___	**Secondary and unspecified malignant neoplasm of lymph nodes (with Cervix Primary)** (Includes **C77.2** - Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes; **C77.4** - Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes; **C77.5** - Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes; **C77.8** - Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions.)	**12 months**
☐ **C79.** ___	**Secondary malignant neoplasm of other and unspecified sites (with Cervix Primary)** (Includes **C79.10** - Secondary malignant neoplasm of unspecified urinary organs; **C79.11** - Secondary malignant neoplasm of bladder; **C79.19** - Secondary malignant neoplasm of other urinary organs; **C79.31** - Secondary malignant neoplasm of brain; **C79.51** - Secondary malignant neoplasm of bone; **C79.52** - Secondary malignant neoplasm of bone marrow; **C79.60** - Secondary malignant neoplasm of unspecified ovary; **C79.61** - Secondary malignant neoplasm of right ovary; **C79.62** - Secondary malignant neoplasm of left ovary; **C79.82** - Secondary malignant neoplasm of genital organs; **C79.89** - Secondary malignant neoplasm of other specified sites; **C79.9** - Secondary malignant neoplasm of unspecified site.)	**12 months**
PRE-CANCEROUS CONDITIONS		
☐ **D06.** ___	**Carcinoma in in situ of cervix uteri** (Includes **D06.0** - Carcinoma in situ of endocervix; **D06.1** - Carcinoma in situ of exocervix; **D06.7** - Carcinoma in situ of other parts of cervix; **D06.9** - Carcinoma in situ of cervix, unspecified.)	**3 months**
☐ **D48.** ___	**Neoplasm of uncertain behavior of other and unspecified sites** (Includes **D48.5** - Neoplasm of uncertain behavior of skin; **D48.60** - Neoplasm of uncertain behavior of unspecified breast; **D48.61** - Neoplasm of uncertain behavior of right breast; **D48.62** - Neoplasm of uncertain behavior of left breast.)	**3 months**
☐ **N87.** ___	**Dysplasia of cervix uteri** (Includes **N87.0** - Mild cervical dysplasia; **N87.1** - Moderate cervical dysplasia; **N87.9** - Dysplasia of cervix uteri, unspecified.)	**3 months**

PROVIDER NAME (Confirming diagnosis)	PROVIDER MPI/NPI NUMBER	TELEPHONE NUMBER
ADDRESS		DATE / /
PROVIDER AUTHORIZED SIGNATURE	DATE / /	**Please fax this application to the Department of Health's HealthyWoman Program Screening Contractor at 412-201-4702.**

Applicant's Name _____ Date ____/____/____

PART III. TO BE COMPLETED BY THE DEPARTMENT OF HEALTH'S HEALTHYWOMAN PROGRAM

Check if requirement is met:

- ☐ Applicant meets the age requirement for BCCPT (under age 65)
- ☐ Application form is complete and signed
- ☐ Allowable ICD diagnosis code

DATE FORWARDED TO CAO	PRINT NAME
/ /	

SIGNATURE

PART IV. TO BE COMPLETED BY COUNTY ASSISTANCE OFFICE

1. ☐ APPLICANT IS ELIGIBLE FOR ONGOING MEDICAID - BEGINNING

MONTH	DAY	YEAR

2. ☐ APPLICANT IS NOT ELIGIBLE FOR ONGOING MEDICAID

REASON FOR REJECTION:

- ☐ NO DOCUMENTATION OF ALIEN STATUS
- ☐ OTHER:

COUNTY NUMBER	
RECORD NUMBER	
CATEGORY	LINE NO.

CAO WORKER'S SIGNATURE	DATE
	/ /