

Breast and Cervical Cancer Prevention and Treatment Program

RENEWAL



pennsylvania
DEPARTMENT OF HUMAN SERVICES

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, Gender, 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 (717-265-8292) or mail the renewal form back to the Office of Medical Assistance Programs at: Department of Human Services, Office of Medical Assistance Programs, Division of Medical Review/BCCPT, PO Box 8050, 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 Human Services

Breast and Cervical Cancer Prevention and Treatment Program

RENEWAL

COUNTY NO.	RECORD NO.	CATEGORY	LINE NO.
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What language do you prefer? ¿Qué idioma prefiere usted? English/Inglés Spanish/Español Other/Otro (specify/especificque) _____
Do you need an interpreter? ¿Necesita un intérprete? Yes / Sí No If yes, what language? En caso afirmativo, ¿de qué idioma? _____

PART I. APPLICANT INFORMATION

YOUR NAME – (First, Middle Initial, Last, Suffix – Jr./Sr./etc.)	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP CODE TELEPHONE ()

COMPLETE THE FOLLOWING INFORMATION AND SIGN BELOW

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? <input type="checkbox"/> Yes	If yes, fill in your document type and ID number: ▶	DOCUMENT TYPE:	DOCUMENT ID NUMBER:
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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 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 a 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 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.

VOTER REGISTRATION (Optional)

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 to vote 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

<input type="checkbox"/> Given to Client __/__/__	<input type="checkbox"/> Sent to voter registration __/__/__	<input type="checkbox"/> Mailed to Client __/__/__
<input type="checkbox"/> Declined, not interested __/__/__	<input type="checkbox"/> Not a U.S. citizen __/__/__	<input type="checkbox"/> Declined, already registered __/__/__

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-10 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.

PROVIDER NAME	PROVIDER M.A.I.D. NUMBER	TELEPHONE NUMBER ()
ADDRESS	CITY	STATE ZIP CODE FAX NUMBER ()

_____ _____
PROVIDER AUTHORIZED SIGNATURE DATE

**Please fax (717-265-8292) or mail this application back to the Office of Medical Assistance Programs at:
PROVIDER: Department of Human Services, Office of Medical Assistance Programs, Division of Medical Review/
BCCPT, PO Box 8050, 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.10 CODE _____

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

NAME	OFFICE	TELEPHONE NUMBER
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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