Attachment C

COVER LETTER BCCPT PARTIAL REDETERMINATION

CAO Letterhead

(Date)

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

Dear (Name)

Your Medicaid eligibility under the Breast and Cervical Cancer Prevention and Treatment Program needs to be reviewed for continuing eligibility by (mm/dd/yy).

Please complete Part I of the enclosed form. Take the enclosed form to the 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 Human Services
Office of Medical Assistance Programs
Division of Medical Review/BCCPT
P.O. 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