Washington State Department of Health

Case Management
Transition to Medicaid for Cancer Treatment
BREAST AND CERVICAL CANCER TRACKING FORM

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

CLIENT NAME (Last, First, MI)		BCCHP PRIME CONTRACTOR	DATE (mm/dd/yyyy)
BCCHP ID #	MEDICAID / ACES ID #	BCCHP CASE MANAGER Name: ________ Phone: ________ Fax: ________	
DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER		

☐ BREAST

Diagnosis Date: ________________

- ☐ Atypical Hyperplasia
- ☐ Invasive Cancer
- ☐ Lobular Carcinoma In Situ
- ☐ Ductal Carcinoma In Situ
- ☐ Diagnosis code - 174.9

Treatment Plan:

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgical: ☐ Lumpectomy
  - ☐ Mastectomy: ☐ Modified ☐ Radical
- ☐ Reconstruction
- ☐ Endocrine Therapy (Type: ____________)

☐ CERVICAL

Diagnosis Date: ________________

- ☐ CIN II
- ☐ Invasive Cancer
- ☐ CIN III
- ☐ Diagnosis code - 180.9

Treatment Plan:

- ☐ Cone
- ☐ Cryo
- ☐ LEEP
- ☐ Hysterectomy
- ☐ Chemotherapy
- ☐ Radiation

TREATMENT INFORMATION

TX START DATE: ________________

TX COMPLETE DATE: ________________

TX SUSPENDED DATE: ________________

- ☐ DECLINES or REFUSES TX
- ☐ LOST TO FOLLOW UP (No shows/ didn't make appointments)

STATUS / COMMENTS / FOLLOW-UP PLAN:

PHYSICIAN (signature): ________________ **DATE:** ________

Medicaid or NPI Number

PHYSICIAN NAME (print): ____________ / ________ **PHONE:** ________

FOR BCCHP CASE MANAGER USE:

DSHS NOTIFIED:

- ☐ AEM ONLY
- ☐ RENEWAL – CLIENT CONTINUES ACTIVE TREATMENT ☐
- ☐ NO LONGER ELIGIBLE FOR BCCHP-MEDICAID (Please check reason)
  - ☐ ALL CANCER TREATMENT COMPLETED ☐
  - ☐ CLIENT TRANSFERRED TO ________________ ☐
  - ☐ CHANGE IN INSURANCE ☐
  - ☐ CLIENT MOVING OUT OF STATE ☐
  - ☐ OTHER ________________

BCCHP CASE MANAGER SIGNATURE: ________________ **Date:** ________

PLEASE FAX TO BCCHP PRIME CONTRACTOR: ________________

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY 1-800-833-6388).