

## BREAST & CERVICAL CANCER TREATMENT PROGRAM TRACKING FORM

Please Print Clearly

<b>Client Last Name</b>	<b>Client First Name</b>	<b>MI</b>	<b>Social Security Number:</b>	<b>Date of Birth:</b>
<b>BCCHP Prime Contractor:</b>		<b>BCCHP ID #</b>	<b>Client Medicaid ID #:</b>	
<b>Provider Name:</b>		<b>Clinic Name :</b>		<b>Clinic Chart #:</b>

☐ **BREAST Diagnosis Date:** \_\_\_\_\_

☐ **Unsp. Benign dysplasia** ☐ Dx code: **N60.99**  
(not available for AEM/ERSO - undocumented)

☐ **Unsp. Type Carcinoma in situ (right)** ☐ Dx code: **D05.91**

☐ **Unsp. Type Carcinoma in situ (left)** ☐ Dx code: **D05.92**

☐ **Malignant Neoplasm (right)** ☐ Dx code: **C50.911**

☐ **Malignant Neoplasm (left)** ☐ Dx code: **C50.912**

☐ **Other** \_\_\_\_\_ ☐ Dx code: \_\_\_\_\_

☐ **Metastatic disease**

**Current Treatment Plan - BREAST:**

☐ **Office Visit to initiate staging and treatment plan**

☐ **Chemotherapy**

☐ **Radiation**

☐ **Endocrine therapy:** \_\_\_\_\_

**Start date:** \_\_\_\_\_ **Proposed End date** \_\_\_\_\_

☐ **Surgery:** ☐ **Excision** ☐ **Lumpectomy**

☐ **Surgery: Mastectomy:** ☐ **Modified** ☐ **Radical**

☐ **Surgery: Reconstruction**  
(not available for AEM/ERSO- undocumented)

☐ **CERVICAL Diagnosis Date:** \_\_\_\_\_

☐ **Moderate Cervical Dysplasia** ☐ Dx code: **N87.1**  
(not available for AEM/ERSO - undocumented)

☐ **Carcinoma in situ endocervix** ☐ Dx code: **D06.0**

☐ **Carcinoma in situ exocervix** ☐ Dx code: **D06.1**

☐ **Malignant Neoplasm** ☐ Dx code: **C53.9**

☐ **Metastatic disease**

**Current Treatment Plan - CERVICAL:**

☐ **LEEP**

☐ **Cone**

☐ **Cryo**

☐ **Hysterectomy**

☐ **Chemotherapy**

☐ **Radiation**

**Treatment Status:** **Current Tx start date:** \_\_\_\_\_ **Tx complete date:** \_\_\_\_\_

**Tx suspended date:** \_\_\_\_\_ ☐ **Declines/refuses Tx** ☐ **Lost to follow-up** (no shows, didn't make appts)

**Treatment Comments / Follow-up Plan:**

**Provider (signature):** \_\_\_\_\_ **Date:** \_\_\_\_\_ **NPI #** \_\_\_\_\_

**Provider Name (print):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Medicaid #** \_\_\_\_\_

### FOR BCCHP CASE MANAGER USE:

☐ **AEM/ERSO eligible only**

☐ **New enrollment**

☐ **Renewal – client continues active treatment**

☐ **Other:** \_\_\_\_\_

**BCCHP Case Manager:**

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

☐ **No longer eligible for BCCTP (S30):**

☐ **All cancer treatment completed**

☐ **Now eligible for Apple Health**

☐ **Now eligible for Medicare**

☐ **Has other Creditable Insurance**

☐ **Moving out of state to:** \_\_\_\_\_

☐ **Transfer to BCCTP there**

**Case Manager Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_