

BREAST AND CERVICAL CANCER TREATMENT PROGRAM COUNTY NOTIFICATION-MEDI-CAL DETERMINATION

Instructions: Complete each space or box. If information does not pertain to this case, indicate with N/A.

To: County: _____ Medi-Cal Liaison Name: _____ Liaison Telephone: _____ Fax Number: _____ E-mail Address: _____	From: State department of Health Services Breast and Cervical Cancer Treatment Program Eligibility Specialist (ES): _____ ES Telephone: _____ ES Fax Number: _____ ES E-mail Address: _____		
BCCTP Beneficiary Information			
Name	Phone number ()	Alternate/Message phone number ()	
Address (number, street)	City	ZIP code	
Authorized representative <input type="checkbox"/> Yes <input type="checkbox"/> No	AR name	AR phone number ()	Beneficiary's primary language
Case Documents in Referral Packet:			
<input type="checkbox"/> BCCTP Application or BCCTP Addendum Application for Signature <input type="checkbox"/> Statement of Citizenship, Alienage, and Immigration Status (MC13) <input type="checkbox"/> Medi-Cal Rights, Responsibilities and Declarations (MC210BC) <input type="checkbox"/> Identifications <input type="checkbox"/> Social security card <input type="checkbox"/> Immigration documents <input type="checkbox"/> Other Health Coverage Information (DHS 6155) <input type="checkbox"/> Last Notice of Action <input type="checkbox"/> Case details <input type="checkbox"/> Other _____			
Reason for Federal BCCTP discontinuance:			
<input type="checkbox"/> Beneficiary has turned 65 years of age on _____. <input type="checkbox"/> Beneficiary has obtained creditable insurance coverage _____. <input type="checkbox"/> Beneficiary no longer needs treatment for breast and/or cervical cancer _____. <input type="checkbox"/> Other _____			