West Virginia

Breast and Cervical Cancer Screening Program

Certificate of Diagnosis for Medicaid Coverage/Eligibility

Client Name: ______________________________________ SSN#: _____________________

BCCSP Screening Clinic: ____

Diagnosis Date: ______________________________

Breast or Cervical Diagnosis that is being treated: **Please Check one**

- ☐ **Atypical ductal hyperplasia**
  (Diagnosis made by excisional biopsy)
- ☐ **Invasive ductal breast cancer**
- ☐ **Invasive lobular breast cancer**
- ☐ **Ductal carcinoma in situ (DCIS)**
- ☐ **Lobular carcinoma in situ (LCIS)**
- ☐ **Metastatic breast cancer**
- ☐ **Adenocarcinoma**
- ☐ **CIN I/mild dysplasia**
- ☐ **CIN II/moderate dysplasia**
- ☐ **CIN III/severe dysplasia**
- ☐ **Carcinoma in situ (CIS)**
- ☐ **Squamous cell carcinoma**
- ☐ **Adenocarcinoma**
- ☐ **Atypical glandular cells/AGUS**
  (cervical only, endometrial/uterine not eligible)

By signing, I certify that this patient is in treatment for the condition indicated above.
(Repeat Pap tests, mammogram, etc. are not considered active treatment.)

Physician's signature: _________________________________ **Date:** _____________________

Physician Name: ____

Physician Phone: ________________________________ **Fax**: ____________________________

Y600 Rev: 06/2022