BREAST AND CERVICAL CANCER SCREENING PROGRAM

West Virginia Department of Health and Human Resources

Office of Maternal, Child and Family Health

Case Management / Medicaid referral

Section I: To be completed by BCCSP Provider.

Client Name: ____ Today's Date: ________________________

Client SSN: ____- ___ - ______ DOB: ___________________ Phone Number: (____) _____________________

Address: ___________________________ City: ___________________ State: _______ Zip: _______________

Clinic Name: ________________ Referring Physician Name: _____________ Phone: (____) ______________

Diagnosis: ____ Diagnosis Date: _________________________

Diagnosis Services Required: ____

Medicaid Referred: ☐ Yes ☐ No Medicaid Referral Date: _________________________

BCCSP Provider Signature: ______________________________ Title: ____________________________

Important --- Please fax form to BCCSP @ 304-558-7164

Section II: To be completed by the treating physician's office.

Date of Visit with Physician: _________________________________ Treatment Planned: ☐ Yes ☐ No

Physician Name: _______________________________ Phone: (___) ___________________

Diagnosis Services and/or Course of Treatment Planned: ____

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Treatment Started Date: _________________________ Treatment Termination Date: ________________________________

Authorized Provider Signature: ________________________________ Title: _____________________________________

Important --- Please fax form to BCCSP @ 304-558-7164

CASE MANAGEMENT USE ONLY: Date assigned to Case Manager: ____________________________________

Date of Initial Patient Contact: __________________ Appt. Date with Patient (if applicable): __________________________

Remarks: ____

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Original: Treating Physician Copy: Patient Copy: Provider