



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



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

<input type="checkbox"/> <b>BREAST</b>	<input type="checkbox"/> <b>CERVICAL</b>
--	--

<b>Diagnosis Date:</b> _____	<b>Diagnosis Date:</b> _____
------------------------------	------------------------------

<input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> Invasive Cancer <input type="checkbox"/> Lobular Carcinoma In Situ <input type="checkbox"/> Ductal Carcinoma In Situ <input type="checkbox"/> Diagnosis code - <u>174.9</u>	<input type="checkbox"/> CIN II <input type="checkbox"/> Invasive Cancer <input type="checkbox"/> CIN III <input type="checkbox"/> Diagnosis code - <u>180.9</u>
--	--

<b>Treatment Plan:</b>	<b>Treatment Plan:</b>
------------------------	------------------------

<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Surgical: <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy: <input type="checkbox"/> Modified <input type="checkbox"/> Radical <input type="checkbox"/> Reconstruction <input type="checkbox"/> Endocrine Therapy (Type: _____)	<input type="checkbox"/> Cone <input type="checkbox"/> Cryo <input type="checkbox"/> LEEP <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation
--	---

**TREATMENT INFORMATION**

<b>TX START DATE:</b> _____	<b>TX SUSPENDED DATE:</b> _____
<b>TX COMPLETE DATE:</b> _____	<input type="checkbox"/> DECLINES or REFUSES TX <input type="checkbox"/> 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:** \_\_\_\_\_

<b>FOR BCCHP CASE MANAGER USE:</b>	<b>DSHS NOTIFIED:</b>
<input type="checkbox"/> AEM ONLY	
<input type="checkbox"/> RENEWAL – CLIENT CONTINUES ACTIVE TREATMENT	<input type="checkbox"/>
<input type="checkbox"/> NO LONGER ELIGIBLE FOR BCCHP-MEDICAID (Please check reason)	
<input type="checkbox"/> ALL CANCER TREATMENT COMPLETED	<input type="checkbox"/>
<input type="checkbox"/> CLIENT TRANSFERRED TO _____	<input type="checkbox"/>
<input type="checkbox"/> CHANGE IN INSURANCE	<input type="checkbox"/>
<input type="checkbox"/> CLIENT MOVING OUT OF STATE	<input type="checkbox"/>
<input type="checkbox"/> OTHER _____	
<b>BCCHP CASE MANAGER SIGNATURE:</b> _____	<b>Date:</b> _____

**PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 324-1408**