WV Department of Health
Bureau for Public Health
Office of Maternal, Child and Family Health
WV Breast and Cervical Cancer Screening Program
Diagnostic and Treatment Fund Application

Patients who have Insurance, Medicare, Medicaid, HMO or Out-of- State residents are not eligible.
Must be enrolled in BCCSP

Last Name: _____ First Name: _____Middle Initial: ___

Street Address: _____ City/Town: _____State: _____ Zip: _____

SSN: _____ DOB: _____ Telephone Number: _____Sex: __M__F

WV Resident? ____ Yes ____ No (If no, stop, the patient is not eligible)

Family Income and Insurance Information: (Must be completed)

Total number of family members: _____ Total gross annual income: _____
Is the patient covered by Medicaid? ____ Yes ____ No (If yes, stop, the patient is not eligible)
Is the patient covered by health insurance or an enrollee of an HMO? ____ Yes ____ No (If yes, stop, the patient is not eligible)

ONLY THE PROCEDURES LISTED BELOW ARE COVERED. TELEPHONE APPROVALS CAN NOT BE ACCEPTED

BREAST REQUEST	**APPLICATION STATUS**
List codes requested for breast diagnostic work-up: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	□ Approved * □ Denied (see comments) ***SUBJECT TO AVAILABILITY OF FUNDS*** Signature Title Date
CERVICAL REQUEST	**Comments**
List codes requested for cervical work-up: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
Physician submitting application fax number required	
Name:	
FEIN:	
Address:	
Phone: Fax:	Return to: Diagnostic and Treatment Fund Breast & Cervical Cancer Screening Program 350 Capitol Street, Room 427 Charleston, WV 25301-3714 Phone: 1-800-642-8522 or (304) 558-5388 Fax: (304) 558-7164
Date submitted:	
Date procedure scheduled:	
Person submitting application:	
Approval/denial to be faxed to:	**Information contained in this application is confidential.**