WV 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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