

WV 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

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

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)

Provider signature: _____ **Date:** _____

Provider Name: _____

Provider Phone: _____ **Fax:** _____

Y600 Rev: 06/2023

