

CONTRACTOR INFORMATION

Breast Cancer Treatment Program Tracking Form

Please Print Clearly

Client Last Name	Client First Name	MI	Social Security Number:	Date of Birth:	
BCCHP Prime Contractor:		BCCHP ID #	Provider One #:		
Primary Care Provider Name:		Enrolling Clinic Name :		Clinic Chart #:	

Breast Diagnosis Date: _____

1. **Unspecified Benign Dysplasia* - Dx code: N60.99**
 (* Unspecified Benign Dysplasia is not a qualifying diagnosis for AEM/ERSO)
2. **Carcinoma in situ (CIS) of breast – Right Side (Choose one from the options below)**
 - Lobular CIS, right - Dx code: D05.01 Intraductal CIS, right - Dx code: D05.11
 - Other CIS, Specified right - Dx code: D05.81 Other CIS, Unspecified right - Dx code: D05.91
3. **Carcinoma in situ (CIS) of breast – Left Side (Choose one from the options below)**
 - Lobular CIS, left - Dx code: D05.02 Intraductal CIS, left- Dx code: D05.12
 - Other CIS, Specified left - Dx code: D05.82 Other CIS, Unspecified left- Dx code: D05.92
4. **Malignant Neoplasm – Right Side - Dx code: C50.911**
5. **Malignant Neoplasm – Left Side - Dx code: C50.912**
6. **Metastatic disease** Site of Metastatic Disease _____

Current Treatment Plan - Breast

- Office Visit to initiate staging and treatment plan Appointment Date: _____
- Chemotherapy Start Date: _____ End Date: _____
- Radiation Start Date: _____ End Date: _____
- Surgery: Excision Lumpectomy Date of Surgery: _____
- Surgery: Mastectomy: Modified Radical Date of Surgery: _____
- Surgery: Reconstruction* Date of Surgery: _____ (* reconstruction not available for AEM/ERSO)
- Endocrine therapy: Prescription Name : _____
- Start date of Endocrine therapy: _____ Proposed end date: _____

Treatment Status: _____ Current Tx start date: _____ Tx complete date: _____

Tx suspended date: _____ Declines/refuses Tx Lost to follow-up (left area, missed appts)

Treatment Comments / Follow-up Plan:

Provider (signature): _____ Date: _____ NPI # _____
 Provider Name (print): _____ Phone: _____ Medicaid # _____

FOR BCCHP CASE MANAGER USE:

- AEM/ERSO eligible only
- New enrollment
- Renewal – client continues active treatment
- Other: _____

BCCHP Case Manager:
 Name & Email:
 Phone: _____ Fax: _____

- No longer eligible for BCCTP (S30):
 - All cancer treatment completed
 - Now eligible for Apple Health
 - Now eligible for Medicare
 - Has other Creditable Insurance
 - Moving out of state to: _____
 - Renewal forms not completed

Case Manager Signature: _____ Date: _____