

ARKANSAS DEPARTMENT OF HEALTH  
*BreastCare*

**Diagnosis Verification and Treatment Plan**

Name of Patient:		Phone number to contact patient:
BreastCare ID #: 7777		BreastCare Plan:
Social Security Number:		
Tissue Diagnosis:	Diagnosis Code:	Date of Diagnosis:
Treatment Required?      Yes      No		
Health Insurance Coverage?      Yes      No		Name Of Insurance:
Breast Treatment Recommendation:		
Surgery      Chemotherapy      Radiation      Tamoxifen/Hormone Therapy		
Cervical Treatment Recommendation:		
Cryotherapy      Hysterectomy LEEP/LETZ      Radiation Conization      Chemotherapy		
Based upon clinical information available on this date, I estimate that the course of treatment for:		
_____		will end on _____
(Name of Patient)		(Date)
<b>Financial eligibility must be assessed annually. If you estimate that this patients's treatment will exceed twelve months, you will receive a form in a year for you to verify that treatment is continuing. For questions, please call 501-661-2636 or 501-661-2018.</b>		
Name of Physician (Please Print):		
Address of Physician:		
Phone Number of Physician:		Speciality:
Signature of Physician:		Date:

**Please complete, sign and fax this form with pathology report report to:**

**501-280-4049**

Arkansas Department of Health

*BreastCare*

4815 W. Markham, Slot 11

Little Rock, Ar. 72205