

ARKANSAS DEPARTMENT OF HEALTH
Breast CARE
 ANNUAL VERIFICATION OF TREATMENT

The following patient has been receiving Medicaid services for one year after her cancer diagnosis. For this patient to remain on Medicaid, she must currently be needing treatment of breast or cervical cancer, limited to surgery, radiation, chemotherapy, or oral hormonal therapy. Your signature will verify her treatment status.

Date: _____

Name of Patient: _____

Social Security #: _____

Diagnosis: _____

Treatment Complete (Please circle/check one):	
Yes _____	
No _____	Name of Treatment Receiving: _____

Eligibility must be assessed annually. For questions, please call 501-661-2636 or 501-661-2018.

Name of PCP or Oncology Provider:	
Address of PCP or Oncology Provider:	
Phone Number of PCP or Oncology Provider:	
Signature of PCP or Oncology Provider:	Date:

Please complete, sign and fax this form to :
 Arkansas Department of Health
BreastCare
Fax number: 501-280-4049

For State Office Use Only		
Patient Meets Eligibility for BreastCare:	Yes _____	No _____
Patient Eligible for Medicaid:	Yes _____	No _____
ADH Official:		Date: