

ARKANSAS DEPARTMENT OF HEALTH
BreastCare

Diagnosis Verification and Treatment Plan

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|---|--------------------|
| Name of Patient: | |
| BreastCare ID #: 7777 | BreastCare Plan: |
| Social Security Number: | |
| Tissue Diagnosis: | 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) |
| Financial eligibility must be assessed annually. If you estimate that this patients's treatment will exceed twelve months, you will receive anotherform in a year for you to verify that treatment is continuing. For questions, please call 501-661-2636 or 501-661-2018. | |
| Name of Physician (Please Print): | |
| Address of Physician: | |
| Phone Number of Physician: | Speciality: |
| Signature of Physician: | Date: |

**Please complete, sign and return this form to:
Arkansas Department of Health
BreastCare
4815 W. Markham, Slot 11
Little Rock, Ar. 72205
or fax to: 501-280-4049**

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