Physician Statement and Certification

To be completed by the physician providing the patient's breast and/or cervical cancer treatment
Medical Doctor (MD) or Doctor of Osteopathy (DO) only

Patient Last Name:	First Name:	Middle Initial:

Date of Birth:	Benefits Identification Card (BIC):	BCCTP Case Tracking Number:

The information requested below is needed to determine if the patient is still in need of treatment and may continue to be eligible for Medi-Cal benefits through the Breast and Cervical Cancer Treatment Program (BCCTP). This completed and signed form must be faxed, emailed, or mailed to BCCTP in an envelope to the address printed at the bottom of this form within 20 days.

Is the patient listed above in need of treatment for breast and/or cervical cancer? ☐ **Yes** ☐ **No**

The term "In Need of Treatment" is defined as "providing medically necessary care and treatment for clinically indicated and documented complications related to the initial qualifying BCCTP diagnosis." Treatment includes surgery, radiation, chemotherapy, and hormonal treatment such as with Tamoxifen.

However, if the patient's cancer is in remission and the physician determines that the patient requires only clinical surveillance and routine health screening for a documented breast or cervical condition (e.g., annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the patient is not considered to be in need of treatment.

Name of Physician:	Title/Specialty:	Phone Number:

Physical or Mailing Address:	City:	State:	Zip Code:

Signature of Physician:	Date Signed:

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