Washington State Department of Health

DOH 140-175 Jan 2018

CONTRACTOR INFORMATION

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

Cervical 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 #:

Cervical Diagnosis Date: _____

1. ☐ **CIN 2/Moderate Dysplasia -** Dx code: **N87.1**
   (*CIN 2 is *not a qualifying diagnosis for AEM/ERSO)*
2. ☐ **CIN 3/severe dysplasia/carcinoma in situ (CIS), stage 0 (choose one from options below)**
   - ☐ **CIS, endocervix -** Dx code: **D06.0**
   - ☐ **CIS, exocervix -** Dx code: **D06.1**
   - ☐ **CIS, other part of cervix -** Dx code: **D06.7**
   - ☐ **CIS, unspecified -** Dx code:**D06.9**
3. ☐ **Adenocarcinoma in situ (AIS) (choose one from option below)**
   - ☐ **AIS, endocervix -** Dx code: **D06.0**
   - ☐ **AIS, exocervix -** Dx code: **D06.1**
   - ☐ **AIS, other part of cervix -** Dx code: **D06.7**
   - ☐ **AIS, unspecified -** Dx code: **D06.9**
4. ☐ **Malignant Neoplasm -** Dx code: **C539.9**
5. ☐ **Metastatic disease** **Site of Metastatic Disease:** _____

Current Treatment Plan - Cervical

☐ **LEEP** **Start Date:**_____ **End Date:**_____
☐ **Cone** **Start Date:**_____ **End Date:**_____
☐ **Cryo** **Start Date:**_____ **End Date:**_____
☐ **Hysterectomy Start Date:**_____ **End Date:**_____
☐ **Chemotherapy Start Date:**_____ **End Date:**_____
☐ **Radiation Start Date:** _____ **End Date:**_____

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

Tx suspended date: _____ ☐ **Declined/refused 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 paperwork not returned**

Case Manager Signature: _____ **Date:** _____