

Breast 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 #:

Breast Diagnosis Date: _____

1. **Unspecified Benign Dysplasia*** - Dx code:N60.99

(* Unspecified Benign Dysplasia is not a qualifying diagnosis for AEM/ERSO)

2. **Carcinoma in situ (CIS) of breast – Right Side (Choose one from the options below)**

Lobular CIS, right - Dx code: D05.01 Intraductal CIS, right - Dx code: D05.11
 Other CIS, Specified right - Dx code: D05.81 Other CIS, Unspecified right - Dx code:D05.91

3. **Carcinoma in situ (CIS) of breast – Left Side (Choose one from the options below)**

Lobular CIS, left - Dx code: D05.02 Intraductal CIS, left- Dx code: D05.12
 Other CIS, Specified left - Dx code: D05.82 Other CIS, Unspecified left- Dx code: D05.92

4. **Malignant Neoplasm – Right Side - Dx code: C50.911**

5. **Malignant Neoplasm – Left Side - Dx code: C50.912**

6. **Metastatic disease**

Site of Metastatic Disease _____

Current Treatment Plan - Breast

Office Visit to initiate staging and treatment plan Appointment Date: _____

Chemotherapy Start Date: _____ End Date: _____

Radiation Start Date: _____ End Date: _____

Surgery: Excision Lumpectomy Date of Surgery: _____

Surgery: Mastectomy: Modified Radical Date of Surgery: _____

Surgery: Reconstruction* Date of Surgery: _____ (* reconstruction not available for AEM/ERSO)

Endocrine therapy: Prescription Name : _____

Start date of Endocrine therapy: _____ Proposed end date: _____

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

Tx suspended date: _____ Declines/refuses 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: _____

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 forms not completed

BCCHP Case Manager:

Name & Email:

Phone:

Fax:

Case Manager Signature: _____

Date: _____