

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 2-3/severe dysplasia** (Please choose one of the diagnostic codes from CIN 3 below)
3. **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
4. **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
5. **Malignant Neoplasm - Dx code: C539.9**
6. **Metastatic disease** Site of Metastatic Disease: _____

Current Treatment Plan - Cervical

- | | | |
|---------------------------------------|-------------------|-----------------|
| <input type="checkbox"/> LEEP | Start Date: _____ | End Date: _____ |
| <input type="checkbox"/> Cone | Start Date: _____ | End Date: _____ |
| <input type="checkbox"/> Cryo | Start Date: _____ | End Date: _____ |
| <input type="checkbox"/> Hysterectomy | Start Date: _____ | End Date: _____ |
| <input type="checkbox"/> Chemotherapy | Start Date: _____ | End Date: _____ |
| <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> AEM/ERSO eligible only
<input type="checkbox"/> New enrollment
<input type="checkbox"/> Renewal – client continues active treatment
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> No longer eligible for BCCTP (S30): <ul style="list-style-type: none"> <input type="checkbox"/> All cancer treatment completed <input type="checkbox"/> Now eligible for Apple Health <input type="checkbox"/> Now eligible for Medicare <input type="checkbox"/> Has other Creditable Insurance <input type="checkbox"/> Moving out of state to: _____ <input type="checkbox"/> Renewal paperwork not returned |
|---|--|

BCCHP Case Manager:

Name & Email:

Phone:

Fax:

Case Manager Signature: _____ Date: _____