

Cabinet for Health and Family Services  
Department for Medicaid Services

**BREAST & CERVICAL CANCER TREATMENT PROGRAM  
REQUEST FOR EXTENSION**

RECIPIENT'S NAME: \_\_\_\_\_

RECIPIENT'S IDENTIFICATION #: \_\_\_\_\_

RECIPIENT'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

A.

SHE IS RECEIVING TREATMENT FOR:

- BREAST CANCER
- CERVICAL CANCER
- PRECANCEROUS CERVICAL OR BREAST DISORDER

B.

RECIPIENT'S MEDICAL AND TREATMENT HISTORY (PLEASE INCLUDE INDICATIONS AND RATIONALE FOR TREATMENT, I.E. PREVENTATIVE, CURATIVE, PALLIATIVE) \_\_\_\_\_

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NEW TREATMENT END DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

TELEPHONE #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ FAX #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

AGENCY USE ONLY

MA END DATE HAS BEEN CHANGED TO: \_\_\_\_/\_\_\_\_/\_\_\_\_

ELIG. POLICY STAFF SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ELIG. MAINT. STAFF SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

