

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) AND WHY THE TREATMENT MUST CONTINUE.

NEW TREATMENT END DATE: ____/____/____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

PHYSICIAN TELEPHONE #: (____)____-____ FAX #: (____)____-____

Fax Completed form to 502-564-0039

AGENCY USE ONLY

MA END DATE HAS BEEN CHANGED TO: ____/____/____

MEDICAID POLICY STAFF SIGNATURE: _____ DATE: _____

MEDICAID POLICY STAFF SIGNATURE: _____ DATE: _____

