

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)**

<input type="checkbox"/> CIS, endocervix - Dx code: D06.0	<input type="checkbox"/> CIS, exocervix - Dx code: D06.1
<input type="checkbox"/> CIS, other part of cervix - Dx code: D06.7	<input type="checkbox"/> CIS, unspecified - Dx code: D06.9
3. **Adenocarcinoma in situ (AIS) (choose one from option below)**

<input type="checkbox"/> AIS, endocervix - Dx code: D06.0	<input type="checkbox"/> AIS, exocervix - Dx code: D06.1
<input type="checkbox"/> AIS, other part of cervix - Dx code: D06.7	<input type="checkbox"/> AIS, unspecified - Dx code: D06.9
4. **Malignant Neoplasm - Dx code: C539.9**
5. **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:

- AEM/ERSO eligible only
- New enrollment
- Renewal – client continues active treatment
- Other: _____

BCCHP Case Manager:
Name: **Stephany Diaz Favela**
Email: stdiazfavela@kingcounty.gov
Phone: 206-263-8309 Fax: 206-296-0208

- 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: _____