

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 allows states to provide full Medicaid benefits to individuals who are found to be in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia). This coverage group is known as the Breast and Cervical Cancer Program (BCCP). The following criteria must be met:



General Information

- The individual is an adult under age 65;
- The individual must meet SC state residency, citizenship/alienage, and identity requirements;
- The individual does not have other insurance coverage that would cover treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia), including Medicare Part A or B;
- The individual's family income is at or below 200% of the Federal Poverty Level; and
- The individual is not eligible for another Medicaid eligibility group.

Upon being diagnosed with breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia) an individual can apply for coverage in the following manner:

things to know



Application Process

1. Complete and sign the Application for Healthy Connections Medicaid (DHHS Form 3400) or apply online at www.scdhhs.gov. The medical provider rendering the diagnosis must complete Form 913-A.
2. The provider rendering the diagnosis must complete and sign the relevant sections on Page 2.
3. The completed application and addendums are faxed to the Breast and Cervical Cancer Program at (803) 255-8237. A Pathology Report indicating the diagnosis and a copy of the applicant's insurance card must be faxed with the application. Note: A cytology report (Pap Smear) is not sufficient.
4. The applicant will be notified in writing of approval or denial of the application. Individuals who qualify are eligible for the full range of Medicaid coverage.
5. Coverage continues as long as eligibility criteria are met and the beneficiary continues treatment. The beneficiary must report to their Medicaid worker when treatment is completed.
6. Eligibility is reviewed annually for individuals with breast or cervical cancer and bi-annually (every six months) for individuals with pre-cancerous lesions. When it is time for the review, a review form is mailed to the beneficiary and must be returned or coverage will stop.
7. Once treatment is completed, the beneficiary must qualify under another Medicaid program for coverage to continue.
8. If you have questions regarding the BCCP, or need help in completing this addendum, please call: 1-888-549-0820 (TTY 1-888-842-3620).

Section I - Applicant Information

Applicant Name (First name, Middle name, Last name) (Print)		Phone	
Street Address	City	State	ZIP
Medicaid ID (if applicable)	Date of Birth	Today's Date	

Section II - Best Chance Network (BCN) Referral

Only complete this section if the applicant is a Best Chance Network Patient. If not BCN please leave this section blank.

BCN Screening Provider Site	Date of BCN Screening
BCN Provider Representative Name (Print)	BCN Provider Representative Signature

Section III - Medical Provider / Non-BCN Referral

Provider Referring Patient to Medicaid (Print)		Phone	
		Fax	
Street Address	City	State	ZIP
Signature			

Has the patient applied for Medicaid? Yes No
To request an application, call (888) 549-0820 or visit www.scdhhs.gov

Has the patient received treatment for one of the following: Yes No
 •Breast cancer •Cervical cancer •Atypical Breast Hyperplasia •Precancerous Cervical Lesion (CIN 2/3)

Date of Diagnosis: _____

Has the patient received treatment for this diagnosis in the past 3 months? Yes No

Did the patient have insurance coverage for these expenses? Yes No

Is the patient in need of continued treatment? *If yes, please send current office notes.* Yes No

Section IV - Authorization to Disclose Health Information - Completed by Applicant

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) to DHEC of all my medical records, education records and other information related to my BCCPTA application.

Signature of Applicant / Beneficiary

Section V - DHEC Office Information

DHEC Employee Assisting with Application (First name, Middle name, Last name)

DHEC Employee Phone Number	DHEC Employee Email
Nurse Case Manager Name (Print)	Nurse Case Manager Signature

Mail to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 Fax to: 803-255-8237

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

