DATE:

BG #:

HH #:

Case Name:

Department of Health and Human Services
REVIEW FORM – Breast & Cervical Cancer Program
(888) 549-0820

BENEFICIARY NAME:

BENEFICIARY ID:

YOU MUST RETURN THIS FORM TO US BY _____.

We must decide if you can continue to get Medicaid. Please have **your doctor who is treating you for your Breast or Cervical pre-cancer or cancer condition** complete and return this form.

Return to: SCDHHS, PO Box 100101, Columbia, SC 29202.

Physician's Name: _____ Address: _____ _____ _____ Phone #: _____ Indicate physician specialty: (Please circle) Oncologist Surgeon Radiologist OB/GYN Is the patient currently receiving treatment for a breast or cervical cancer or precancerous condition? (Please circle one) YES NO	How long do you anticipate treatment for cancer? Do not include post-treatment follow-up. _____ **Please attach a progress note to this review form.** Specify the type of treatment being received: (Indicate all that apply) Chemotherapy Radiation Hormonal Other: _____ If specified hormonal therapy, indicate the current year of treatment. (Please circle) 1 2 3 4 5 > 5

_____ _____
Signature of Attending Physician Date

RIGHTS AND RESPONSIBILITIES

1. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability Act of 1995 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

    a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification of other information.

    b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about me and my family with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

    c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

    d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

2. I know that my Social Security Number, which I am required to provide, under § 1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be sued or released in connection with the exceptions in Item 1, above.

3. I know that according to Federal law and US Department of Health and Human Services (DHHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

4. I know that I must report any and all changes in my income, members of the household, or other information what will affect my eligibility within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

5. I know that I may request a hearing if I believe and error has been made in processing my application.

I know that, as an applicant or benificiary of Medicaid, when I am asked to sign forms related to my application or coverage, that I am signing under penalty of perjury. This means I have provided true answers to all the questions to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.