TEXAS Health and Human Services

**Form H1550**
**July 2015**

Medicaid for Breast and Cervical Cancer

# Out of State NBCCEDP Verification

| Name (Last, First, Middle Initial) | Date of Birth (mm/dd/yyyy) | Social Security Number |
|---|---|---|
| | | |

**Out of State NBCCEDP (Option 1, 2 or 3) Verification:**

Was the above person certified through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP)?..... ☐ Yes ☐ No

If yes, please complete the following information:

| Breast and Cervical Cancer Program (BCCP) Contractor Number | Certifying Individual |
|---|---|
| Program Site | Area Code and Telephone Number |
| Medicaid Provider Number | Case Manager |

Is the individual currently receiving Medicaid benefits in this state?.....☐ Yes ☐ No

If no, provide the Medicaid denial effective date:

I certify that this applicant is a qualified participant in the NBCCEDP (Option 1, 2 or 3).

| Signature | Date |
|---|---|
| Area Code and Telephone Number | Area Code and Fax Number |
| Address | Organization |

When completed, return this form to the following address or fax to **1-877-447-2839.**

**Texas Health and Human Services Commission**
**P.O. Box 149027**
**Austin, TX 78714-9027**

If you have any questions, call 2-1-1 or 1-877-541-7905.

**I,** _____ **give my permission to release the information requested on this form.**
Yo, _____ doy mi permiso para que se divulgue la información que se pide en esta forma.

_____ _____
**Signature**/Firma **Date**/Fecha