

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,<br>Yo, _____        | <b>give my permission to release the information requested on this form.</b><br>doy mi permiso para que se divulgue la información que se pide en esta forma. |
| _____                  | _____                                                                                                                                                         |
| <b>Signature/Firma</b> | <b>Date/Fecha</b>                                                                                                                                             |