



Alabama Breast & Cervical Cancer Program Medicaid Treatment Referral Form for Women Diagnosed with Breast/Cervical Cancer

Date: _____

Physician: _____

AL License #: _____

Person completing form: _____

Phone # of person completing form: _____

PATIENT INFORMATION

1. Last name: _____ 2. First name: _____ 3. MI: _____

4. Social security # _____ - _____ - _____ 5. Date of Birth: _____ / _____ / _____

6. Age: _____ 7. Phone #: (_____) _____

8. Patient's address: _____

(City)

(State)

(Zip)

9a. Family monthly income: _____

10. Family Size: _____

9b. Family yearly income: _____

11. Insurance coverage? Yes No
(Circle one)

12. U.S. Citizen? Yes No
(Circle one)

MEDICAL INFORMATION

13. Type of Diagnosis:

☐ 13a. Breast ☐ 13b. Cervical

☐ CIN II

☐ CIN III

☐ Carcinoma

Pathology report
must be attached

14. Date of Diagnosis: _____ / _____ / _____

15. Has patient begun treatment? Yes No
(Circle one)

Eligibility Information

- 1) 64 years of age or under
- 2) No insurance
- 3) Income at or below 250% of poverty level
income table at: <https://www.alabamapublichealth.gov/bandc/index.html>
- 4) Citizen of Alabama

Contact Information

Please fax/email form & pathology report to
your Regional Coordinator or for more
information, contact Kelli Hardy at
phone: (334) 206-2976
fax: (334) 206-3738
kelli.hardy@adph.state.al.us