Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
FAX: 1-800-498-1255

Statement of Continuing Cancer Treatment

Medical Assistance - BCC Program

Note: This form must be completed by a physician

_____ _____ _____

Patient Name: Date of Birth: Case Number

Dear Sir or Madam:

The above-named patient is currently receiving healthcare coverage under the Medicaid program. In order to determine ongoing eligibility, we must determine if the person is still receiving cancer treatment. Please complete the following information on the patient.

1. Are you currently providing cancer-related treatment for this individual? ☐ No ☐ Yes If yes, list type of cancer:

_____

2. Describe any cancer-related treatment you are currently providing :

_____
_____
_____

3. List any medication you have prescribed for the patient for cancer treatment, including dosage and frequency:

_____
_____
_____

4. When do you expect cancer treatment to end?

_____
_____

_____ _____

Physician's Signature Date

_____ _____

Physician's Office Address City, State, Zip

_____

Phone