ES- 3822
07-01-06

NOTICE OF REVIEW
Medical Assistance - BCC Program

Review Label Goes Here

Dear Madam:

You are currently receiving health care coverage through the Breast and Cervical Cancer (BCC) offered under Medicaid. We must review your case at least once a year to determine if you still qualify. We are reviewing your case this month.

In order to complete the review, you must provide the following items:

1. Complete the attached Application For Medical Coverage. Make sure to sign the bottom of the form. Return the completed form to the address below.

2. We must verify you are receiving ongoing treatment for cancer. Ask your treating physician to complete the attached Statement of Continuing Cancer Treatment and return it to our office. Our address is on the form. **Your physician must complete the form.**

Your coverage expires on _____ . If you do not return these required

forms by _____ your coverage will expire.

This action is based on the Kansas Economic and Employment Support Manual sections 1412 and 9700.

If you have questions, call _____ at _____

Return the form to the following address: