Medicaid Treatment Act (MTA) Client Eligibility Enrollment Procedure

June 2022

BC3NP
Breast & Cervical Cancer Control Navigation Program

Table of Contents

I. Introduction

Women meeting the eligibility criteria in this policy can enroll in the Breast and Cervical Cancer Control Navigation Program (BC3NP) Medicaid Treatment Act (MTA) program to receive breast or cervical cancer treatment. Yearly, the woman's eligibility for continued coverage will be evaluated. Coverage will be renewed if all eligibility criteria are met and she is receiving cancer treatment or receiving care due to a side effect of treatment. MTA coverage will be terminated if eligibility criteria is not met or cancer treatment has ended.

II. Eligibility Criteria for Program Enrollment

Eligibility criteria for enrollment in the BC3NP MTA program to receive cancer treatment are as follows:

A. Age and Income
   1. Age 21-64[1,2]
   2. Income $\leq$ 250% Federal Poverty Level[1,2] (FPL)

B. Residency/Citizenship Status
   1. Current Michigan resident[2]
   2. US citizen/legal resident, registered alien or refugee as defined by the Michigan Department of Health and Human Services[4] (MDHHS)

C. Cancer Diagnosis
   1. Current breast or cervical cancer diagnosis requiring treatment[2,3]
   2. Breast cancer: Invasive Breast Cancer, Ductal Carcinoma in Situ (DCIS), Lobular Carcinoma In Situ (LCIS)
   3. Cervical Pre-Cancerous Lesion: CIN 2, CIN 3/CIS
   4. Cervical Cancer: Invasive Adenocarcinoma, Invasive Squamous Cell Carcinoma

D. Insurance Requirements[3,4]
   1. Uninsured Women: eligible to enroll in BC3NP MTA
   2. Underinsured Women: may be eligible to enroll depending on type of insurance and coverage (see below).

a. Client has insurance that is classified as non-creditable[4]
   - Non-Creditable[4] insurance coverage is defined as health insurance that contains a pre-existing condition exclusion, which either excludes treatment of breast or cervical cancer, or covers limited services, but not treatment for breast or cervical cancer. (§2701(c) of the Public Health Services Act, 42 U.S.C. §300gg(c).

b. Client has started treatment but stopped because her insurance carrier has terminated insurance coverage.

c. Client's insurance has **not** paid for cancer treatment received by the client.

   (1) Clients enrolled in **private insurance** obtained through the Marketplace:
      - Regardless of deductible amount, client **must** dis-enroll from the Marketplace Insurance **prior** to enrolling in BC3NP MTA.
      - If insurance through the Marketplace has paid for any of the client's treatment the client is ineligible for BC3NP MTA.

   (2) Clients enrolled in an **employer sponsored** insurance plan, **note** marketplace insurance:
      - Insurance deductible is **greater than $1,500:** Client is eligible to enroll in BC3NP MTA. Client **does not** have to dis-enroll from employer insurance.
      - Insurance deductible is **less than $1,500:** Client is eligible to enroll in BC3NP MTA. Client **must** dis-enroll from employer insurance PRIOR to enrolling in BC3NP MTA

   (3) **Exception:** Clients enrolled in Healthy Michigan Plan (HMP) or another type of Medicaid **are** eligible to transfer to BC3NP MTA at any time during their cancer treatment.

d. **Final decision of client eligibility to enroll or re-enroll in MTA is determined by the BC3NP Director/Nurse Specialist.**

III. Enrolling New Clients in BC3NP MTA

A. New clients can be enrolled in BC3NP MTA only by a Local Health Department BC3NP Coordinator or designated Local Health Department Program Staff. Questions regarding client eligibilty for the BC3NP MTA can be directed to the Program Director or Nurse Specialist.

B. For Clients **not eligible** or **denied** coverage through BC3NP MTA

- The BC3NP coordinator/staff person will assist the client in obtaining cancer treatment through appropriate providers.
- Non citizens are eligible for Emergency Services Only (ESO) through BC3NP MTA. ESO coverage does not cover cancer treatment.

C. BC3NP Coordinator/Staff member responsibilities: (See Appendix A for Eligibility Checklist)

1. **Explain** MTA program requirements to the client that include:
   a. BC3NP Eligiblity Criteria (age, income, insurance, current treatment)
   b. Duration of MTA Coverage
   c. Yearly renewal of MTA coverage
   d. Criteria for termination of BC3NP MTA
2. **Obtain** required documentation
   - Client's pathology report to confirm a breast or cervical cancer or cervical pre-cancerous condition.
   - Citizenship AND identity documentation as requested by MDHHS (Appendix B).
   - Citizenship AND identity documentation are faxed with the application to Medicaid for review. **Do not** fax client's pathology report.
3. **Complete** BC3NP MTA Application (DCH 1088) (Appendix C)
   - Client completes all boxes top of form and signs name under Applicant's Signature.
   - BC3NP Coordinator/Staff member completes Treatment Begin date and End Date (if known) on application and signs application. (Appendix D)

4. **Fax (do not mail)** MTA application and copies of appropriate citizenship/ identification documentation to Venetta Tucker, Medicaid Quality Analyst, at 517-241-0051.
   - **Do not** fax client's pathology report
5. **File original** MTA application, citizenship/identification documentation and a copy of the pathology report confirming breast/cervical cancer or cervical pre-cancerous condition in the client's chart at the BC3NP agency.
   - BC3NP MTA applications and all supporting documentation **must** be retained for **seven years**.

IV. Arranging for Cancer Treatment of MTA Clients

A. BC3NP Coordinator/Staff responsibilities:

1. **Assist** client in:
   - Identifying/contacting appropriate Medicaid enrolled provider(s) (surgeons, medical oncologists and/or radiation oncologists) to provide breast or cervical cancer treatment.
   - Arranging for transportation to treatment (if needed). (Appendix E: *Instructions for MTA Clients Requiring Reimbursement for Transportation, DCH 5330 Medical Verification for Transportation form, and MSA-4674 Medical Transportation Statement.*
   - Identifying/contacting community resources and/or breast cancer nurse navigators in arranging for additional support as needed for treatment.
2. **Notify** client's provider with date MTA begins for the client.

V. Duration/Termination of Medicaid Coverage for BC3NP MTA Women

A. Client is eligible to receive BC3NP MTA coverage as long as she:

1. **Meets** BC3NP age, income, insurance eligibility requirements[1,2] **and**
2. Is currently receiving breast or cervical cancer treatment **or**

3. Is currently receiving follow-up care to monitor the effectiveness of treatment or care for a side effect related to treatment according to the woman's health care provider.[3]

B. Breast or cervical cancer treatment[5,6,7] is defined as the following:

1. Breast or cervical cancer surgical procedures.
2. Provision of chemotherapy/hormonal therapy/endocrine therapy to treat the breast or cervical cancer.
3. Provision of radiation therapy to treat the breast or cervical cancer.
4. Treatment of side effects relating to the type of breast or cervical cancer therapy received by the woman.

C. Duration of MTA Treatment

Length of treatment depends on the type of cancer diagnosed and cancer treatment. (Appendix D)

D. MTA Coverage Termination

1. MTA coverage will be terminated at any time if the client:
   - Turns 65
   - Reports income over 250% FPL
   - Has obtained creditable insurance that covers cancer treatment
   - Is eligible for Medicare Part A and Part B
   - Is eligible for SSI
   - Has completed breast/cervical cancer treatment and has returned to surveillance monitoring
   - Cannot be located after three attempts at contact
   - Fails to comply with cancer treatment recommendations
2. **Notify** Venetta Tucker, MTA Quality Specialist, via email with the client Medicaid ID # only and the reason for termination.
   - Venetta will inform the coordinator of MTA end date.
   - ALL breast and invasive cervical cancer clients are notified via letter from Venetta Tucker when the end date is determined.
   - Clients with CIN 2 or 3 are notified of both start and end dates for Medicaid when enrollment into the program is confirmed.
3. **Contact** the client to inform her:

- Reason BC3NP MTA is terminated.
- Date MTA coverage will end.
- Additional resources that may assist her for other health related problems, enrollment in marketplace insurance, applying for Healthy Michigan Plan, etc.

VI. Yearly Renewal (Redetermination) Of BC3NP MTA Eligibility

A. Clients enrolled in BC3NP MTA are re-evaluated yearly by BC3NP coordinator/staff person to determine continued eligbility for the program.

B. Prior to the anniversary date (one year from the client's enrollment date into the BC3NP MTA) Venetta Tucker will send a "Redetermination Report" to each agency listing MTA client names and the due date for re-determination.

C. BC3NP Coordinator/Staff person responsibilities:

1. **Review** the "Redetermination report"
   - Report lists MTA client names, Medicaid ID number, and month renewal is due
   - Document "renew" or "discontinue" (and reason) next to client's name on report once status is determined **or**
   - Complete MTA Client Status Update Report (Appendix F)
   - Fax report when complete to Venetta Tucker at 517-241-0051
2. **Contact**:
   a. Clients Listed on Report
      - Review continued eligiblity for program and status regarding cancer treatment
      - **Three** (3) tries to contact client should be attempted. If client unable to be contacted, notify Venetta Tucker to terminate client's MTA coverage.
   b. Client's Treatment Provider
      - Obtain status of cancer treatment

- Document verbal conversation from provider in client's medical record or mail BC3NP *Client Medicaid Renewal for Continued Breast or Cervical Cancer Treatment form (Appendix G)* for provider to complete.

3. **Complete** BC3NP MTA application (DCH 1088)
   a. The same application is used for New *and* Renewing clients.
      - For Renewing clients, document RENEWAL on top of MTA application form.
   b. Citizenship and identify information **are not** required for renewing clients (unless a change in name or address has occurred during the past year).
   c. Application **can be mailed** to the client if client unable to present in person to sign renewal application.
   d. Fax completed application to Venetta Tucker.

VII. BC3NP MTA Hearing/Appeal Rights

A. Appealing MTA Terminations
   1. Clients can appeal the decision regarding MTA termination by requesting an administrative hearing before the **Michigan Office of Administrative Hearing and Rules (MOAHR).**
   2. The client needs to submit a written request for the appeal to MOAHR.
   3. The client may select, at her discretion, legal counsel to represent her during the administrative appeal.
      - MOAHR will review the request and contact both the client and the BC3NP Director with notification of date and time of her hearing by the Administrative Law judge.
      - The client will be assigned a MOAHR Docket number that is used on all correspondance with MOAHR and the client.

B. BC3NP Director Responsibilities:
   1. Contact the BC3NP Coordinator who terminated the client's MTA and request the cancer treatment and other information on the client that determined her ineligibility for continued coverage through the BC3NP MTA.

2. Provide a written summary of the reason(s) the BC3NP MTA coverage was discontinued for the client to the MOAHR Judge and the client.

C. MOAHR Hearing Date

1. The MOAHR hearing is conducted via a three way conference call between the Judge, the BC3NP Director and the client.
2. The participants are sworn in by the judge prior to the hearing.
3. Each participant presents a summary of the case.
4. A time period for final questions is given by the judge.
5. Hearing is recessed and the judge will issue a final verdict within 30 days to uphold the MTA termination or re-instate the client's coverage based on the information presented during the hearing.

VIII. MDHHS BC3NP MTA Contact Staff

Venetta Tucker, TuckerV@michigan.gov
Quality Assurance Analyst
Phone: (517) 241-8682, Fax: (517) 241-0051

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BC3NP Lay Navigator
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BC3NP Nurse Specialist
Phone: (517) 243-8246, Fax: (517) 763-0290

IX. References

1. Michigan Breast and Cervical Cancer Control Navigation Program Eligibility Criteria.
2. Public Law 106-354, Breast and Cervical Cancer Mortality Prevention Act of 1990 Amendment to Public Law 106-354, Breast and Cervical Cancer Prevention and Teatment Act of 2000.
3. Health Care Financing Administration. Breast and Cervical Prevention and Treatment Act of 2000 – Frequently Asked Questions, page 5, question 14.
4. Centers for Medicare and Medicaid Services. Breast and Cervical Prevention and Treatment Act of 2000. Questions 10, 17, 18.
5. National Cancer Institute - Breast Cancer Treatment - Health Professional Version Updated February 2, 2016. http://www.cancer.gov/types/breast/hp
6. National Comprehensive Cancer Network Clinical Practice Guidelines for Breast Cancer, Version 2, 2016. https://www.nccn.org/professionals/physician_gls/PDF/breast.pdf
7. National Cancer Institute - Cervical Cancer Treatment – Health Professional Version Updated February 4, 2016. http://www.cancer.gov/types/cervical/hp

Appendix A.
MTA Eligibility Application Checklist

MTA Eligibility Application Checklist for New Client Enrollments

Steps Required to Complete Application	Check
Explain MTA program requirements to client: • BC3NP Eligibility Criteria (age, income, insurance, current treatment) • Duration of MTA Coverage • Yearly renewal of MTA coverage on anniversary date • Criteria for Termination of BC3NP MTA	
Obtain required documents • Client's Pathology report confirming cancer diagnosis • Citizenship and Identity documentation	
Complete BC3NP MTA Application (DCH 1088) entering treatment begin dates and end dates (If known for cervical pre-cancerous conditions)	
Fax application, Citizenship, and Identity documents to Venetta Tucker (Fax: (517) 241-0051). **Do not fax pathology report.**	

Diagnosis	Treatment Start Date	Treatment End Date
Breast Cancer (all types)	First day of month biopsy is performed	Leave blank
Cervical cancer (invasive)	First day of month biopsy is performed	Leave blank
CIN 2	First day of month treatment is scheduled	2 months coverage for treatment. May be extended.
CIN 3/CIS	First day of month treatment is scheduled	6 months coverage for treatment. May be extended.

Appendix B.
MTA Citizenship/Identity Documentation Requirements

Citizenship/Identity Documentation Requirements for BC3NP MTA Enrollment

Eligibility requirements for BC3NP MTA include verification of the client's citizenship and identify by producing any of the following documents:

Citizenship Documentation

- U.S. Passport
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Birth certificate
- Report or certification of birth abroad of a US citizen
- U.S. Citizen ID card
- Adoption papers
- Military record if it shows state born
- Voter ID Card
- Enhanced Michigan Driver's License

Identity Documentation - (Photo ID)

- Driver's License/Photo ID Card
- U.S. Passport (can be also used for citizenship documentation)
- School Photo ID
- Federal, state, or local government ID
- U.S. military ID card

Note: If the client cannot obtain the required citizenship / identity documentation:

- Inform the client that she has **15 calendar days** to produce the missing citizenship or identity documentation.
- Inform Venetta Tucker, Medicaid Quality Analyst, that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.
- If unable to obtain documentation during that time or if the client requires assistance in obtaining supporting documents (e.g., a copy of her birth certificate), notify BC3NP Nurse Specialist or Director.

Appendix C.
Breast and Cervical Cancer Treatment Program (MTA) Medicaid Application (DCH 1088)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM
APPLICATION FOR MEDICAID

Last Name	First Name	Middle Initial

Address	Apt. or Lot Number

City	State	Zip Code	County	Birthdate (MM/DD/YYYY)
	MI			

Social Security Number	Phone Number (Area Code, Number)	Treatment Begin Date	Treatment End Date	Do you intend to stay in Michigan?
				☐ YES ☐ NO

Are you a United States citizen? (If NO, attach a copy of USCIS status.)
☐ YES ☐ NO

Racial /Ethnic Heritage: _____(optional codes noted in bold)
A-Asian or Pacific Islander; **B**-Black or African American (Non-Hispanic); **E**-Other Race or Ethnicity; **H**-Hispanic; **I**-Native American / American Indian / Alaskan Native **J**-Native Hawaiian; **O**-Caucasian/White (Non-Hispanic); **Z**-Mutually Defined or Multiracial

Do you have health insurance? ☐ YES ☐ NO
If YES, name of insurance company
Policy Number

ACKNOWLEDGEMENTS

This is your copy of your rights and responsibilities as an applicant for or beneficiary of Medicaid benefits. By signing the application you acknowledge that you understand your rights and responsibilities and that you are applying only for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP).

I agree to the release of information and supporting proof in order to evaluate and verify eligibility. I agree that the Department of Community Health (DCH) or Local Public Health agency may use necessary medical information about me, including any information about HIV or AIDS, to determine eligibility for a specific program or for other administrative purposes. I understand that these agencies will maintain confidentiality according to federal requirements at 42 CFR 431.300-431.307 and any other applicable federal and state laws and regulations.

I understand that when the DCH pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the Department. Payment of any recovery under such right is to be made directly to the State of Michigan, DCH, or its agent.

I understand that this application is only for Medicaid coverage under the BCCPTP. I understand that if found not eligible for health benefits under the BCCPTP, I may be eligible for Medicaid benefits on some other basis. I understand I have the right to complete the DHS-1171 to apply for cash benefits, food assistance, day care assistance or other services at the local Department of Human Services (DHS) office.

I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits received.

I understand that I must report changes, such as name, address, Medicaid program participation, or health insurance coverage, within 10 days of the change. I understand that computer cross-checking may be used to verify information I have provided on this application.

If you would like help with the pursuit of financial or medical support, contact your local DHS office. If you need help with reading or writing to complete this application, under the Americans with Disabilities Act you are invited to make your needs known to your local treatment program case manager.

You have the right to appeal a decision by the Department of Health and Human Services. You will be notified of your rights if your application is denied for any reason.

SIGN YOUR APPLICATION

I certify under penalty of perjury that the information on the application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize the state to verify the information on this application.

Applicant's Signature
Date

I certify that this applicant meets all eligibility criteria for the BCCPT program. Case Manager/Breast and Cervical Cancer Control Program (BC3NP) Coordinator Signature
Date

Printed Case Manager/BC3NP Coordinator Name
Telephone Number

Citizenship documentation attached? ☐ YES ☐ NO
Identity documentation attached? ☐ YES ☐ NO

FAX APPLICATION AND DOCUMENTATION TO **VENETTA TUCKER**: **(517) 241-0051**

Authority: Social Security Act XIX, Public Law 106-354.
Completion: Is Voluntary, but is required if Medical Assistance Program Payment is desired.
DCH-1088 (08/08) Previous editions are obsolete.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Appendix D.
MTA Breast and Cervical Treatment Start/End Dates

Guidelines for Determining Breast and Cervical Cancer Treatment Start/End Dates

Breast Cancer Treatment Start Dates

1. Breast Cancer Diagnosis: **LCIS**

Treatment Options	MBCIS Treatment Start Date	MTA Application Start Date	MTA Application End Date
a. Observation ONLY after Biopsy confirming diagnosis. No further surgery scheduled **and** client **not eligible** for Targeted Drug Therapy	Date of **biopsy** confirming cancer diagnosis	1st of month cancer diagnosed from biopsy	**End** date is 2 months (60 days) from MTA start date if no targeted drug therapy prescribed.
b. Targeted Drug Therapy to decrease the incidence of subsequent breast cancers (Requires Oncology Consult visit)	Date of Oncology Consult visit and verification client has the prescribed targeted drug therapy medication for treatment.	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until targeted drug therapy is completed.
c. Bilateral prophylactic total mastectomy, without axillary node dissection.	Date of **biopsy** confirming cancer diagnosis	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until therapy is completed.

2. Breast Cancer Diagnosis: **DCIS**

Treatment Options	**MBCIS Treatment Start Date**	**MTA Application Start Date**	**MTA Application End Date**
a. Breast-conserving surgery (lumpectomy) without lymph node surgery and radiation therapy with or without targeted drug therapy	Surgery date. If targeted drug therapy is prescribed prior to surgery, then record Oncology Consult date.	1st month cancer diagnosed from biopsy	No **end** date. MTA continues until targeted drug therapy is completed OR resolution of side effects (if any) from radiation or targeted therapy.
b. Total Mastectomy with **or** without sentinel node biopsy with or without reconstruction and Targeted Therapy.	Surgery date. If chemotherapy/ targeted drug therapy is prescribed prior to surgery then record Oncology Consult date.	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until chemotherapy/targeted drug therapy is completed.

3. Breast Cancer Diagnosis: **Invasive Breast Cancer**

Treatment Options	**MBCIS Treatment Start Date**	**MTA Application Start Date**	**MTA Application End Date**
a. Breast –conserving surgery with axillary node staging and radiation therapy with or without chemotherapy and/or targeted therapy.	Surgery date. If chemotherapy/ targeted drug therapy is prescribed prior to surgery, then record Oncology Consult date.	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until chemotherapy and/or targeted therapy is completed.
b. Mastectomy (**first**) with axillary node staging with or without reconstruction followed by radiation, chemotherapy, and/or targeted therapy.	Surgery date. If chemotherapy/ targeted drug therapy is prescribed prior to surgery, then record Oncology Consult date.	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until radiation, chemotherapy and/or targeted drug therapy completed OR breast reconstruction completed
c. Neoadjuvant therapy (Targeted therapy or Chemotherapy **prior** to surgery to shrink tumors)	Date of Oncology Consult visit. Need verification client has the prescribed drug therapy.	1st of month cancer diagnosed from biopsy	No **end** date. MTA continues until targeted therapy and/or chemotherapy completed.

Cervical Cancer/Pre-cancer Treatment Start Dates

1. Cervical Cancer Diagnosis: **CIN 2 (pre-cervical cancer)**

Treatment Options	**MBCIS Treatment Start Date**	**MTA Start Date**	**MTA End Date**
a. Surgical procedure (LEEP, Conization)	Date of Surgical Procedure (LEEP, Cone) **post** Biopsy	1st of month treatment is scheduled	**End** date is two months (60 days) **post** procedure. This includes month of LEEP/Cone and one-month post. Can be extended if dysplasia identified on LEEP/Cone.

2. Cervical Cancer Diagnosis: **CIN 3/CIS**

Treatment Options	**MBCIS Treatment Start Date**	**MTA Start Date**	**MTA End Date**
a. Surgical procedure (LEEP, Conization).	Date of Surgical Procedure **Post** Biopsy	1st of month treatment is scheduled	Last day of month six months post treatment. Can be extended.
b. Hysterectomy for CIN 3/CIS if dysplasia involves margins.	Date of Surgical Procedure **Post** Biopsy	1st of month treatment is scheduled	Last day of month six months post treatment. Can be extended.

3. Cervical Cancer Diagnosis: **Invasive Cervical Cancer Adenocarcinoma or Squamous Cell Carcinoma**

Treatment Options	**MBCIS Treatment Start Date**	**MTA Start Date**	**MTA End Date**
a. Hysterectomy b. May include chemotherapy and/or radiation therapy if needed	Date of Surgical Procedure POST Biopsy	1st of month treatment is scheduled	No **end** date. MTA continues until treatment completed per surgeon or oncologist.

Appendix E.
BC3NP Medical Verification for Transportation Form (DHS 5330) and Instructions for Completion

Instructions for MTA Clients Requiring Reimbursement for Transportation

Effective 9/16/2021

BC3NP Medicaid Treatment Act (MTA) Program clients requesting transportation reimbursement must complete the following 2 forms to receive reimbursement for transportation:

- Medical Transportation Statement (MSA-4674)
- Medical Verification for Transportation Form (DHS-5330)

Instructions for Form Completion

1. Venetta Tucker, Medicaid Quality Analyst, will mail the MSA-4674 (Medical Transportation Statement) to the client with the client's renewal letter.
   - The form contains directions for completion and when the form must be returned.
   - Client to mail form to: Attention: Venetta Tucker, BC3NP, 400 S. Pine Street. Lansing, MI 48393.

2. BC3NP Coordinator
   a. Yearly, at the time of the client's renewal, complete the Medical Verification for Transportation form (DHS-5330).
   b. Coordinator fills in the Client's Name, Date of Birth, Medicaid ID Number, and Address.
   c. Completion of medical questions A-G on the form.
      - BC3NP Coordinator can ask the client the questions or
      - Mail the application to the client with instructions to complete A-G

3. Required Signatures
   a. BC3NP MTA has been granted an exception from Medicaid so BC3NP coordinators can sign the Verification for Transportation form in place of the client's medical provider.
   b. Under Medical Provider Name: enter N/A.
   c. Under Medicaid Enrolled Provider Signature: cross out and enter BC3NP MTA Enrollment Coordinator and sign your name.

d. Under Patient's or Representative's Signature: Client signs in this box and provides signature date.
e. Under MDHHS Specialist Name: Venetta Tucker will sign the form when she receives it. Fax the form along with the renewal application to Venetta Tucker at (517) 241-0051.

4. Form Retention
   - The original signed form (like the client's MTA applications) should be kept in the client's file for 7 years.

MEDICAL TRANSPORTATION STATEMENT

Michigan Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area.
MDHHS employees are prohibited by law from providing legal advice.
Si Ud. no entiende esto, llame a su oficina local del MDHHS.
La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا المكتب، فاتصل بمكتب MDHHS الموجود في منطقتك.
يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

Case Name:
Case Number:
Date:
MDHHS Office:
Co: District: Section: Unit: Worker:
Specialist / ID: /
Phone:
Fax:
Individual ID:

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Title XIX of the Social Security Act.

COMPLETION: Is voluntary but required if payment from applicable programs is sought.

SIGMA Doc Code	SIGMA Doc Unit	SIGMA Doc ID

☐ One-time appointment ☐ On-going appointments

SECTION I - MDHHS Specialist Completes Only **ONE** medical provider and **ONE** transporter per form.

Beneficiary Name	Beneficiary Street Address	Apt. No.	City	State	Zip Code

Phone No.	Medicaid ID No.	Level of Care Code	TOA

Directions to the House

Special Instructions (Disabled, wheelchair, car seats, etc.)

Medical Provider Name	NPI No.	Medical Provider Street Address	Suite	Phone No.

City	State	ZIP Code

SECTION II - Transportation Provider

Transportation Provider Name	Soc. Sec. No. or TIN No.

Provider Street Address	City	State	Zip Code	Phone No.

SECTION III - Transportation Record (Provider / Transporter / Beneficiary Complete):

Appointment Date	Appointment Time	Departure Date and Time	Return Date and Time	Round Trip Miles	Attendant Initials	Medical Provider's Signature
TOTAL					I certify that I provided attendant service on the date(s) above.	I certify that I am a Medicaid enrolled provider and that I provided a medical service on the appointment date(s) above.

Beneficiary Signature	Date

Transporter Signature	Date
I certify that I provided the above service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. Any third-party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.	

MSA-4674 (Rev. 10-17) Previous edition obsolete. 1

Case Name	Case Number	Specialist

SECTION IV - Local MDHHS Specialist & Manager Complete

A)___ Miles X $____ (Appropriate mile-age rate)	$	D) Lodging	$	G) Total Auth (Lines A through F)	$	
B) Lift/Medivan Base Rate	$	E) Meals	$	MDHHS Specialist's Signature		Date
C) Fees and Tolls	$	F) Attendant(s)	$	MDHHS Manager's Signature		Date
Is the transportation provider CHAMPS enrolled? Yes ☐ No ☐ Not Applicable ☐						

SECTION V - Local MDHHS Office Use Only

Audited and ~~Approved~~ by:				Date
Budget Fiscal Year	Unit	Accounting Template	Department Object	Amount
				$

Instructions for MSA-4674 (Medical Transportation Statement)

- Use this form for 5 or less trips made in a month. Use 1 medical provider per form and 1 transportation provider per form.
- This form must be returned to the MDHHS local office within **90 calendar days** from the last date of service to authorize payment for medical transportation.

SECTION I:
- The MDHHS Specialist completes this section.

SECTION II:
- The transportation provider completes this section.
- Leave this section BLANK if the beneficiary drives themselves OR if the beneficiary wishes to receive the transportation payment directly.

SECTION III - Transportation Record:
Transporter:
- Enter the following for each appointment / visit: date, departure time, return time, number of miles traveled (round trip) and the attendant initials, if medically necessary.
- If SECTION III was completed, then only that transporter may sign at the bottom of this section.
- By signing this form, I certify that I provided the stated service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. Any third party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.

Medical Provider (or their designee):
- Confirm the date(s) and time(s) of appointment(s) and sign your name to verify that the medical visit did occur.

Beneficiary:
- Sign the form to certify you received the transportation on the dates identified.

SECTION IV:
- The MDHHS Specialist calculates the transportation payment and signs their name and dates.
- The MDHHS Manager reviews the entire form and signs their name and dates, approving the payment.
- The local office must then submit this form to the appropriate MDHHS Accounting Service Center within 10 business days of receipt of the form.
- Transportation providers must be CHAMPS enrolled to receive mileage reimbursement from Medicaid for medical transportation services.

SECTION V:
- The local MDHHS office completes this section.

COPY DISTRIBUTION:
Original: - Mail or give this copy to the **Beneficiary** for completion by the Beneficiary, medical provider and the transporter.
- **Return to MDHHS Specialist** for completion. Forward to the local MDHHS Accounting Unit for payment processing.
Copy 1: - Local MDHHS Case File copy.
Copy 2: - Give this copy to the Transporter Provider.

MSA-4674 (Rev. 10-17) Previous edition obsolete. 2

Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.
Si usted no entiende esto, llame a una oficina de MDHHS en su área. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب MDHHS الموجود في منطقتك. يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MEDICAL VERIFICATION FOR TRANSPORTATION

INSTRUCTIONS: To be completed annually by a physician (MD or DO). Please print or type.

Medical Provider:
Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's Name	Patient's Birthdate	Medicaid ID #

Patient Street Address	Apt/Suite	City	State	Zip Code

Preferred Contact Number	

☐ A	Does the patient have a chronic ongoing illness which may require multiple visits to a provider? ▶ ☐ YES ☐ NO	
☐ B	If yes to line A, what is the illness?	
☐ C	Estimated number of office or clinic visits ____ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)	Will this change? ☐ YES, When ____ (Date) ☐ NO
☐ D	Patient's current status: ☐ Non-ambulatory ☐ Walks without restrictions ☐ Walks without assistive devices ☐ Walks with assistive device(s) ☐ Limited mobility with assistive device(s) (relies on wheeled mobility)	
☐ E	Does the patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶	
☐ F	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?
☐ G	Other (Explain)	

Medical Provider Name	National Provider Identifier (NPI)	Provider's Phone No.
		– –

Street Address (No., Street, Bldg.)	Suite	City	State	ZIP Code

Medicaid-enrolled Provider Signature	Signature Date

MDHHS Specialist Name (Print or type)	Signature Date

MDHHS Specialist Signature	I certify that the beneficiary meets requirements as listed in the Medicaid Provider Manual to receive Medicaid non-emergency medical transportation.
Patient's or Representative's Signature	Signature Date

DHS-5330 (Rev. 3-17) Previous edition may be used.

Appendix F.
BC3NP MTA Client Status Update

Medicaid Treatment Act

Client Status Update

Memorandum

Date:

To: Venetta Tucker, Quality Assurance Analyst

Fax: 517-241-0051

From:

RE: BC3NP MTA Client Status Update

The following BC3NP client:

Name: _____ Beneficiary ID Number: _____

Has / is:

☐ Completed cancer treatment

☐ Failed to renew yearly application

☐ Non-compliant with treatment

☐ Obtained Insurance

☐ Other: _____

Medicaid end date is: _____

Please call _____ if you have any questions.

Thank you.

Appendix G.
BC3NP MTA Client Renewal for Continued Breast or Cervical Cancer Treatment

MEDICAID TREATMENT ACT

CLIENT RENEWAL FOR CONTINUED
BREAST OR CERVICAL CANCER TREATMENT

Agency Name: _____

Date sent to Provider: _____

BCCCNP Client Name: _____ Date of Birth: _____

In order to determine continued eligibility for Medicaid services, please indicate below the status of the above named BCCCNP client.

- ❑ The client is still receiving treatment for (check one):
  - ❑ Breast cancer
  - ❑ Cervical cancer
  - ❑ CIN II
  - ❑ CIN III/CIS

- ❑ FOR CERVICAL CANCER TREATMENT:
  The client has completed cancer treatment. She received _____ (procedure) on _____ (date). *

- ❑ FOR BREAST CANCER TREATMENT:
  The client has completed cancer treatment and can return to routine or surveillance screening.

_____ _____
Signature Date

Additional Information:


BC3NP
Breast & Cervical Cancer
Control Navigation Program