MAP-813D
(Rev. 8/2023)

Cabinet for Health and Family Services
Department for Medicaid Services

BREAST & CERVICAL CANCER TREATMENT PROGRAM
REQUEST FOR EXTENSION

This application is to be submitted only by Kentucky Women's Cancer Screening Program (KWCSP) staff or their designated entities. For more information or to find a KWCSP provider, please call (844) 249-0708.

RECIPIENT'S NAME: ____

RECIPIENT'S IDENTIFICATION #: ________________________

RECIPENT'S DATE OF BIRTH:__________/________/__________

STREET ADDRESS: ____

CITY:______________________________STATE:_________ZIP: _______________

A. SHE IS RECEIVING TREATMENT FOR:

☐ BREAST CANCER

☐ CERVICAL CANCER

☐ PRECANCEROUS CERVICAL OR BREAST DISORDER

B. RECIPIENT'S MEDICAL AND TREATMENT HISTORY (PLEASE INCLUDE INDICATIONS AND RATIONALE FOR TREATMENT, I.E. PREVENTATIVE, CURATIVE, PALLIATIVE) AND WHY THE TREATMENT MUST CONTINUE.

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NEW TREATMENT END DATE:__________/_______/______

PHYSICIAN'S SIGNATURE: ____________________________________

DATE: ______________________________

PHYSICIAN TELEPHONE #: (________)_______-______FAX #: (______)_______- ______

Fax Completed form to 502-564-0039

AGENCY USE ONLY
MA END DATE HAS BEEN CHANGED TO:__________/_____/_______

MEDICAID POLICY STAFF SIGNATURE:_____________________________DATE:_____________

MEDICAID POLICY STAFF SIGNATURE:_____________________________DATE: _____________

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