



Breast and Cervical Cancer Treatment Program (BCCTP) User Guide

California Medicaid Management Information System

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Overview

The Breast and Cervical Treatment Program (BCCTP) provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer who have met the Centers for Disease Control and Prevention (CDC) screening criteria. Every Woman Counts (EWC) and Family Planning, Access, Care, and Treatment (Family PACT) screening providers are authorized to screen and enroll applicants into BCCTP. These providers enroll eligible applicants into BCCTP by using the Breast and Cervical Treatment Program (BCCTP) application in the Medi-Cal Provider Portal.

Objectives

The objective of this user guide is to provide step-by-step instructions for submitting presumptive eligibility requests in the Medi-Cal Provider Portal BCCTP application.

Tips and Troubleshooting

- Required fields are indicated by an asterisk (*). Fields without an asterisk are optional.
- Each session will have a 30-minute time-out if no action is taken. To ensure that progress isn't lost, it is recommended that you review and complete the online application in a timely fashion.

Prepare to Submit a BCCTP Application

There are two documents that will help prepare a provider to submit a BCCTP presumptive eligibility request in the Medi-Cal Provider Portal Breast and Cervical Cancer Treatment Program (BCCTP) application:

- *Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers*
- *Breast and Cervical Cancer Treatment Program Medi-Cal Application*

Both of these documents may be accessed from the **Need Help?** drawer in the BCCTP application. Refer to the “Access Provider Portal BCCTP Application” section of this user guide.

Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers

The purpose of the *Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers* document is to assist providers in determining if an individual is eligible to submit a BCCTP application.

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Breast and Cervical Cancer Treatment Program Medi-Cal Application

The *Breast and Cervical Cancer Treatment Program Medi-Cal Application* document must be printed and completed with an applicant to determine if the individual is eligible for Medi-Cal under BCCTP rules. The document must be signed by the applicant and submitted to DHCS one of the following ways:

- Email to BCCTP@dhcs.ca.gov
- Fax to 916-440-5693
- Mail to:

Department of Health Care Services
Breast and Cervical Cancer Treatment Program
MS 4611
P.O. Box 997417
Sacramento, CA 95899-7417

Access Provider Portal BCCTP Application

1. Navigate to the [Medi-Cal Providers website](#) and click **Login to Provider Portal**.

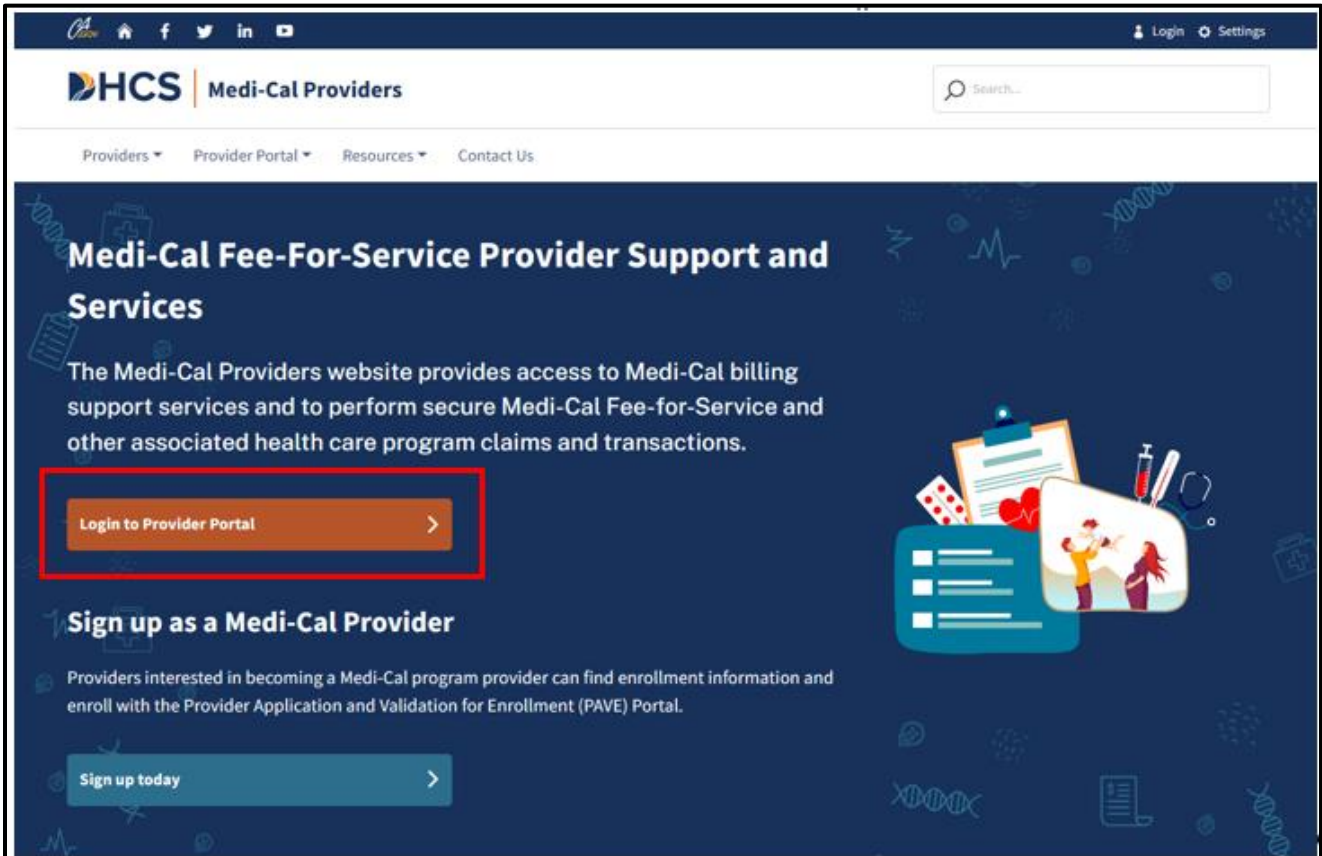


Figure 1.1: Provider Portal Link.

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2. On the Dashboard Transaction Center tile, click **Get Started**.

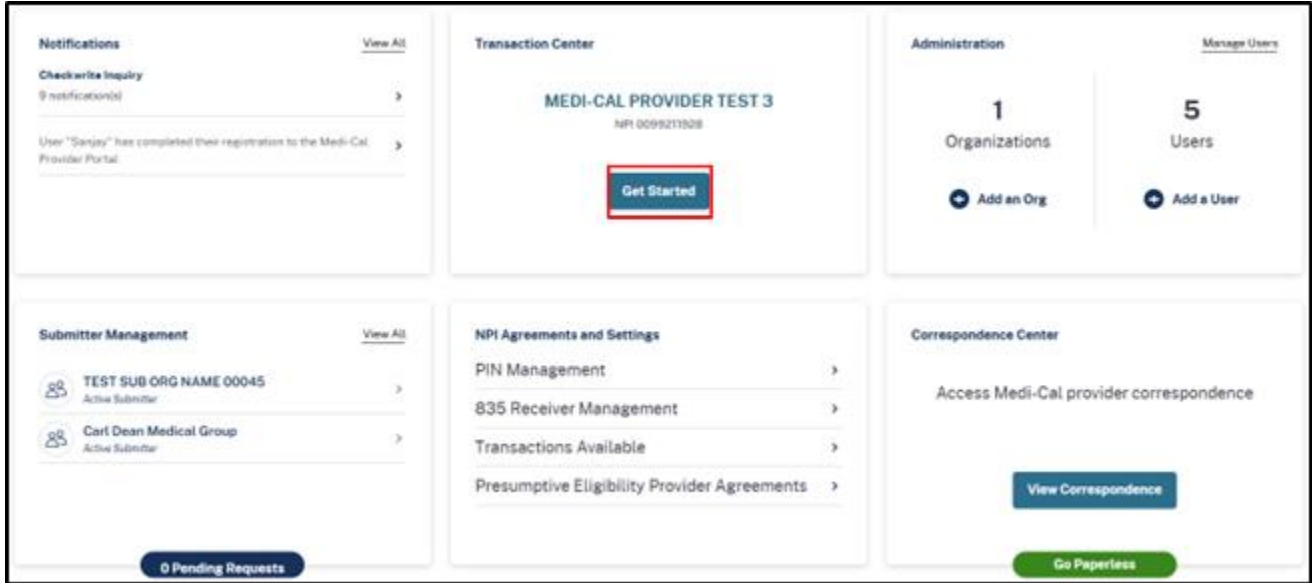


Figure 1.2: Get Started.

3. In the Enrollment section, click **Breast and Cervical Cancer Treatment Program**.

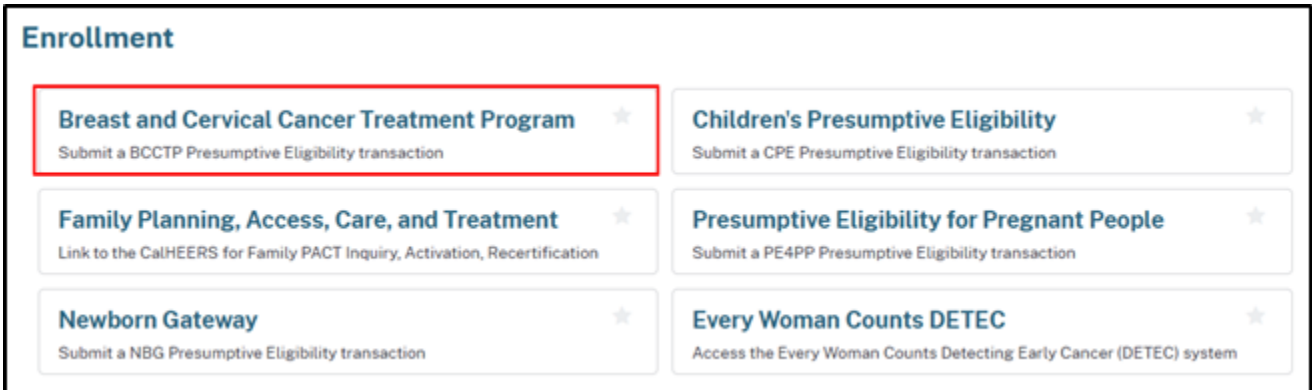


Figure 1.3: Breast and Cervical Cancer Treatment Program Link.

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4. Click the **Need Help?** drawer.

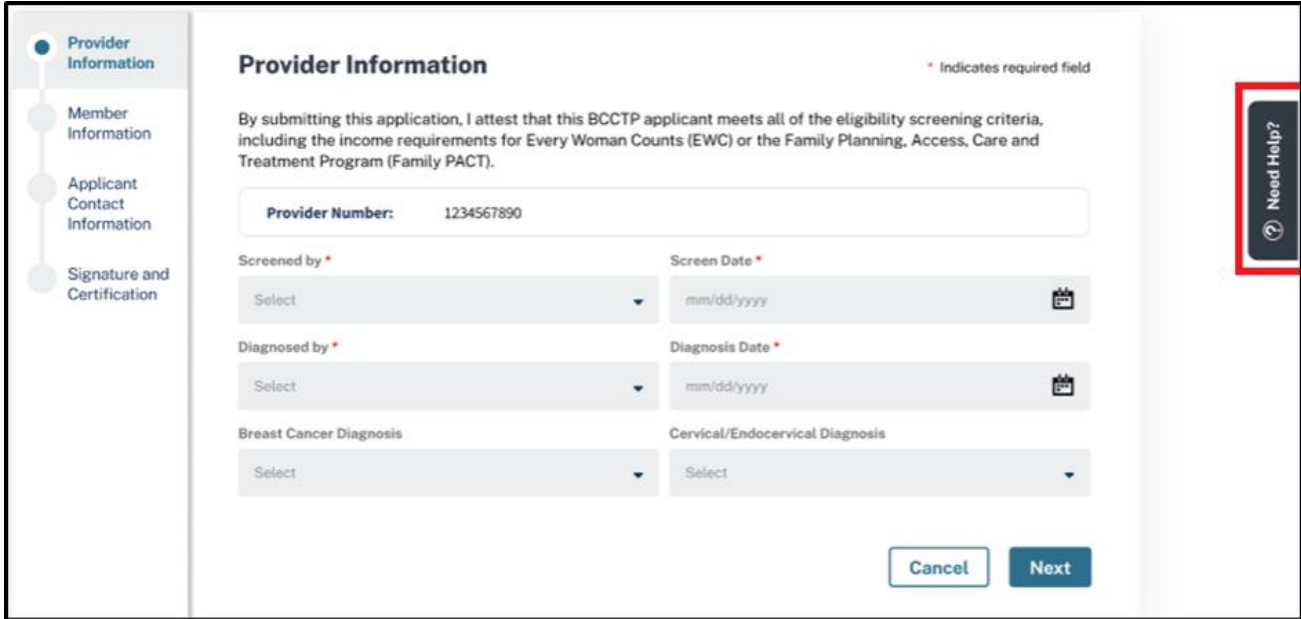


Figure 1.4: Need Help? Drawer.

5. Click **Supplemental Materials** to access the BCCTP resources page to download and print the BCCTP application in English or Spanish, and to access other resources.

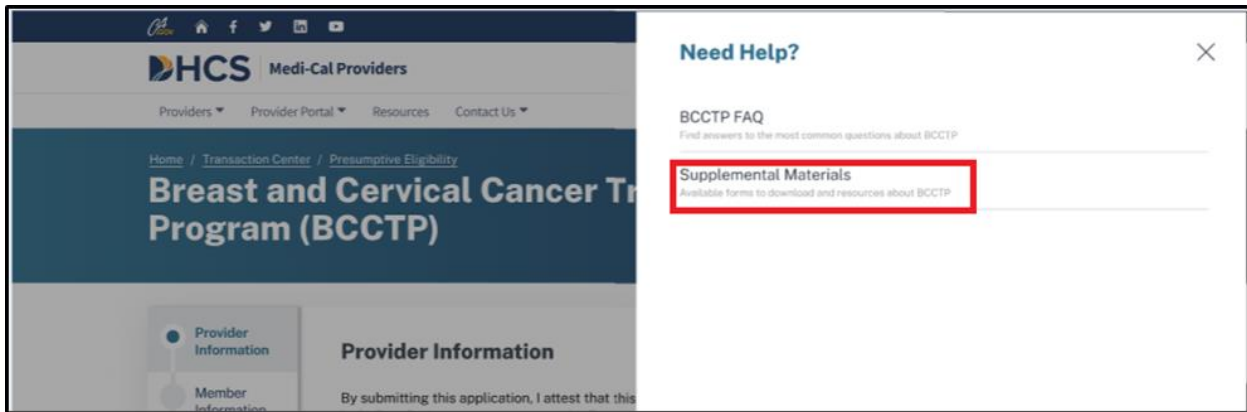


Figure 1.5: Supplemental Materials Link.

Submit BCCTP Application

After collecting the applicant's information and signature from the *Breast and Cervical Cancer Treatment Program Medi-Cal Application*, enter the information in the Provider Portal BCCTP application.

1. In the Provider Portal BCCTP application, complete the **Provider Information** page and click **Next**.

The screenshot shows the 'Provider Information' form in the BCCTP application. On the left is a vertical navigation menu with five items: 'Provider Information' (selected), 'Provider Contact Information', 'Applicant Information', 'Verification', and 'Signature and Certification'. The main content area is titled 'Provider Information' and includes a legend: '* Indicates required field'. Below the title is a disclaimer: 'By submitting this application, I attest that this BCCTP applicant meets all of the eligibility screening criteria, including the income requirements for Every Woman Counts (EWC) or the Family Planning, Access, Care and Treatment Program (Family PACT)'. The form contains the following fields: a text input for 'Provider Number' with the value '1234567890'; a dropdown for 'Screened by' with 'Select' chosen; a date input for 'Screen Date' with the format 'mm/dd/yyyy' and a calendar icon; a dropdown for 'Diagnosed by' with 'Select' chosen; a date input for 'Diagnosis Date' with the format 'mm/dd/yyyy' and a calendar icon; a dropdown for 'Breast Cancer Diagnosis' with 'Select' chosen; and a dropdown for 'Cervical/Endocervical Diagnosis' with 'Select' chosen. At the bottom right are two buttons: 'Cancel' and 'Next', with the 'Next' button highlighted by a red border.

Figure 2.1: Provider Information.

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2. Complete the **Provider Contact Information** page and click **Next**.

Provider Contact Information * Indicates required field

Please complete this section in its entirety as we will have to contact you if there are any questions about the application once submitted.

Enter name of staff person submitting this on-line application

Staff Last Name * Staff First Name * Staff Title *

Insert Insert Insert

Direct Telephone Number * Extension

(###) ###-#### ####

Facility/ Office Information

Facility/Office Name *

Insert

Street Address *

Number and Street

City * State * ZIP Code *

Insert CA Insert

Best Time to Call Email Address

Insert Insert

Alternate Staff Contact Person Facility/Office Telephone Number (if different)

Insert (###) ###-####

Cancel Previous **Next**

Figure 2.2: Provider Contact Information.

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3. Complete the **Applicant Information** page and click **Next**.

Applicant Information * Indicates required field

Personal and Contact Information

If you only use one name, enter pound sign (#) in First Name field and enter your name in the Last Name field only.

Last Name * First Name * Middle Initial Suffix

Insert Insert Insert Select

Social Security Number

Insert

A Social Security Number is required for full benefits. If you do not have one now, you can apply now and give us the number within 60 days, or if you are an undocumented immigrant, you can obtain breast and cervical cancer treatment emergency service without a Social Security Number.

Gender * Male Female Date of Birth * mm/dd/yyyy

Place of Birth

County of Birth (if California) State of Birth (if Not California County)

Select Select

Home Address

If homeless, check the box and indicate (below) where to send any written correspondence.

In Care of (IC/O)

Insert

Street Address *

Number and Street

City * State * ZIP Code *

Insert CA Insert

County you live in *

Select

Mailing Address (if different than above)

In Care of (IC/O)

Insert

Street Address

Number and Street

City State ZIP Code

Insert CA Insert

Contact Information

What is the best way to contact you? Email Address What is the best time to call?

Select Insert Select

Home Phone Message Phone Mobile Phone

Insert Insert Insert

Spoken Language * Written Language *

Select Select

Medicare Coverage Information

	Yes	No
Do you have Medicare Part A (Inpatient)? *	<input type="radio"/>	<input type="radio"/>
Do you have Medicare Part B (Outpatient)? *	<input type="radio"/>	<input type="radio"/>
Do you have Medicare Part D (Prescription Drug Coverage)? *	<input type="radio"/>	<input type="radio"/>

Other Health Insurance Information

	Yes	No
Do you have other comprehensive medical coverage? *	<input type="radio"/>	<input type="radio"/>

If yes, identify Health Insurance Carrier(s). Select ALL that apply *

<input type="checkbox"/> Military Benefits Comprehensive	<input type="checkbox"/> Multiple Plans Comprehensive
<input type="checkbox"/> Medicare Part C (Advantage)	<input type="checkbox"/> Kaiser
<input type="checkbox"/> Medical Parolee	<input type="checkbox"/> Any carrier outside of those listed (includes multiple coverage)
<input type="checkbox"/> PPO/HMO/EPO	

Cancel Previous **Next**

Figure 2.3: Applicant Information.

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4. Complete the **Verification** page and click **Next**.

Verification * Indicates required field

Additional Questions

This form is to apply for immediate Medi-Cal health care services for this month and next month. Do you also want to use this application to get ongoing Medi-Cal coverage through BCCTP? * Yes No

You must apply for Medi-Cal at your local county social services office to continue your BCCTP benefits. This is because you need to be evaluated for all benefits. You do not need to apply at the county if you have submitted a Medi-Cal application within the last 45 calendar days of this application date.

Have you had medical expenses within the last three (3) months? * Yes No

Medi-Cal

Do you have a Benefits Identification Card (BIC)/Client Identification Number (CIN)? * Yes No

BIC/CIN

What is the identification number on your card? (if available)

Applicant Information

Are you pregnant? * Yes No

Children Expected:

How many children are you expecting? *

Your answers to these questions provide information about your family size. Be sure to count your unborn child(ren).

Household and Income Details

How many family members live in your household? *

(Include parent, spouse, and any children under age 21 living in the household)

How much is your monthly household income before taxes? *

Alternate Forms

Do you need information in an alternative format? Yes No

Select a format type: * Format Type:

Figure 2.4: Verification.

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- The **Signature and Certification** page contains a checkbox for providers to attest that the applicant has signed the paper *Breast and Cervical Cancer Treatment Program Medi-Cal Application*. Select the checkboxes and click **Next**.

The screenshot shows a web application interface for the 'Signature and Certification' step. On the left, a vertical navigation menu lists five steps: 'Provider Information', 'Provider Contact Information', 'Applicant Information', 'Verification', and 'Signature and Certification'. The 'Signature and Certification' step is currently selected, indicated by a blue circle. The main content area is titled 'Signature and Certification' and includes a sub-header '* Indicates required field'. Below the title, there is a paragraph of text: 'By submitting this application, I attest that this BCCTP applicant meets all of the eligibility screening criteria, including the income requirements for Every Woman Counts (EWC) or the Family Planning, Access, Care and Treatment Program (Family PACT)'. A checkbox is present with the label 'Check this box to certify that the applicant has signed the application. *'. At the bottom of the page, there are three buttons: 'Cancel', 'Previous', and 'Next'. The 'Next' button is highlighted with a red border.

Figure 2.5: Signature and Certification.

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- Read the Application Summary, ensuring that all of the information is correct. If a correction is required, click **Previous** to correct any errors on a previous page. Click **Print** at the top of the screen to print two (2) copies of the Application Summary. Provide one copy to the applicant and place a second copy in the individual's file. Click **Submit**.

- Provider Information
- Provider Contact Information
- Applicant Information
- Verification
- Signature and Certification

Application Summary Print

BREAST AND CERVICAL CANCER TREATMENT PROGRAM APPLICATION

Application Date/Time: 11/23/2024 11:42:01 AM

PROVIDER CONTACT INFORMATION

Service Location Name

Service Location Address Number and Street <small>1234 Street Name</small>	City <small>Cityexample</small>	State <small>Stateexample</small>	ZIP Code <small>90000</small>
---	------------------------------------	--------------------------------------	----------------------------------

Staff Last Name <small>Namesexample</small>	Staff First Name <small>Namesexample</small>	Staff Title <small>Titlesexample</small>	Direct Telephone Number <small>(000) 000-0000</small>
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Facility/Office Email Address
email@example.com

Facility/Office Telephone Number (if different)
(000) 000-0000

APPLICANT INFORMATION

Last Name <small>Namesexample</small>	First Name <small>Namesexample</small>	Middle Initial	Suffix
--	---	----------------	--------

If homeless, check the box and indicate (below) where to send any written correspondence.

Home Address Number and Street <small>1234 Street Name</small>	City <small>Cityexample</small>	State <small>Stateexample</small>	ZIP Code <small>00000</small>
Mailing Address (if different) Number and Street		City	State ZIP Code

Date of birth (month/day/year) <small>11/23/2023</small>	Gender <small>Female</small>	Applicant's Social Security Number <small>000-00-0000</small>
County of residence <small>Countyexample</small>	County of birth <small>Countyexample</small>	State of birth <small>Stateexample</small>

Spoken Language <small>English</small>	Written Language <small>English</small>
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Do you have Medicare Part A (Inpatient)? <small>Yes</small>	Do you have Medicare Part B (Outpatient)? <small>No</small>
Do you have Medicare Part B (Prescription Drug Coverage)? <small>No</small>	Do you have other comprehensive medical coverage? <small>No</small>

VERIFICATION

Do you also want to use this application to get ongoing Medi-Cal coverage through BCCTP?
Yes

Have you had medical expenses within the last three (3) months?
No

Do you have a Benefits Identification Card (BIC)? <small>No</small>	Applicant's BIC/ID
--	--------------------

Are you pregnant?
No

How many family members live in your household?
3

Do you need information in an alternative format?
No

Monthly Income Amount <small>\$3,000</small>	Parent Type
---	-------------

WHO CAN SIGN THIS APPLICATION?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal.
- The conservator, guardian executor, or caretaker of a child who wants Medi-Cal.
- Someone acting for the person who needs Medi-Cal when the person is incompetent, in a custodial condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor.

SIGNATURE AND CERTIFICATION

Check this box to certify that the member has signed the application.

REQUIRED:

- 1. Enter Application tracking Number (located in the center of the Confirmation Documents)
- at the top of each page of the application (where indicated);
- at the bottom of each page of the Rights & Responsibilities form (in the application tracking Number box). Include the name of the beneficiary in the Name box as well.

SUBMIT APPLICATION:

1. Email to bcctp@hcs.ca.gov OR;
2. Fax to 916-443-5693 OR;
3. Mail the following documents via USPS to the address below:
 - Original signed Application
 - Original signed Rights and Responsibilities forms

Department of Health Care Services
Breast and Cervical Cancer Treatment Program
MS-4603
PO Box 987417
Sacramento, CA 95889-7417

Cancel
Previous
Submit

Figure 2.6: Application Summary.

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7. A **Confirmation Document** appears with a response message. The individual and provider must read the response message carefully because it contains important information about the applicant's presumptive eligibility. Click **Print** to print two (2) copies of the **Confirmation Document**. Give one to the applicant for immediate use until a Benefits Identification Card (BIC) is received through the mail. Place the other copy in the individual's file. Provide a paper copy of the *Breast and Cervical Cancer Treatment Program Directions to Apply for Medi-Cal*, available on the Medi-Cal Providers website, whether the individual is eligible or not for BCCTP PE.

Note: If the applicant would prefer a large print version of the **Confirmation Document**, the user may select the checkbox to **View response message in a larger font**, which will print the document in a large print version.

To initiate another transaction, click **Next Application**.

The screenshot displays a web interface for a 'Confirmation Document'. At the top left, there is a checkbox labeled 'View response message in larger font'. The main content area is titled 'Breast and Cervical Cancer Treatment Program Response' and includes the following information:

- Application Date/Time: 10/23/2024 11:42:01 AM
- Provider Number: 0123456789
- Member Name: TEST TESTING
- Date of Birth: 12/12/1999
- BIC: [REDACTED]
- BIC Issue Date: 01/23/2024
- Application Tracking #: 38495

A large, faint watermark of the State of California seal is visible in the background. Below the information, there is a paragraph of text: 'Response #0023: You have been granted temporary, full-scope Medi-Cal coverage effective today under the Breast and Cervical Cancer Treatment Program (BCCTP) while your ongoing eligibility is being decided. Use this Confirmation Document to get all of your medical services with a Medi-Cal doctor until you get your Benefits Identification Card in the mail. Your State Eligibility Specialist will tell you when your ongoing eligibility has been decided. If you have any questions about your application for this program, please call 1-800-824-0088 (toll-free).' At the bottom left, there is a 'Client Signature:' label followed by a horizontal line. At the bottom right, there are two buttons: 'Print' and 'Next Application', both highlighted with a red border.

Figure 2.7: Confirmation Document – Eligible for PE.

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Confirmation Document

View response message in larger font

Breast and Cervical Cancer Treatment Program Response

Application Date/Time: 10/14/2024 3:27:58 PM

Provider Number: #####

Member Name: Test Testing

Date of Birth: MM/DD/YYYY

BIC/CIN: #####A#####

BIC Issue Date: MM/DD/YYYY

Application Tracking #: ###

Response ###: You are not eligible for Presumptive Eligibility (PE) because you have already received PE enrollment within the past 12 months. Individuals are limited to one PE enrollment within the past 12 months of applying.

Client Signature: _____

Figure 2.8: Confirmation Document – Not Eligible for PE.

Change Summary

Version Number	Date	Description	Notes/Comments
1.1	May 2025	New Provider Portal User Guide for the BCCTP Medi-Cal Application	Provider Portal project
1.2	September 2025	Title change	None
1.3	October 2025	User Guide Template update.	Removed "Page Updated: Month Year" on each page. Changed CA-MMIS to California Medicaid Management Information System.
1.4	March 2026	Screen shot update	Rights and Responsibilities checkbox removed from the BCCTP Medi-Cal Application