Georgia Department of Public Health

FY2014

Cancer State Aid Program (CSA)
Medical Eligibility Form – 3621D
Request for Diagnostic Services Funding

Please review form guidance before completing.

Patient Last Name **First Name** **Middle Initial**

☐ **New CSA patient** ☐ **Re-certification** _____

Social Security Number Date of Birth Age

_____

Name of treatment facility City

_____

Required: Contact Name for questions Phone Fax *Email

Completion of this form may be delegated to a registered nurse or other qualified person who has been provided appropriate medical information. The form must be signed by either the treating physician or a nurse in the Cancer/Oncology Unit or Department.

***Applications lacking complete medical information will not be considered*.**

Attach all medical documentation of the suspected cancer and/or need for staging services.

Female patients in need of diagnostic services related to Breast and Cervical Cancers should be referred to the Breast and Cervical Cancer Program (404) 657-3156.

There are two categories of medical eligibility for diagnostic services:

1. ☐Yes ☐No This patient has a condition **highly suspicious for cancer** and needs DIAGNOSTIC services.

   DIAGNOSTIC SERVICES are needed to confirm the presence or absence of cancer, **and** to provide complete STAGING, and a TREATMENT PLAN.

   This category includes patients having the signs, symptoms, physical findings, laboratory studies or imaging studies that document a condition highly suspicious for cancer.

   Documentation of the highly suspicious condition is required with the application.

   Presumed site/description of cancer: _____

2. ☐Yes ☐No This patient has a **diagnosed cancer** and needs STAGING & TREATMENT PLANNING services.

   This category includes patients already having a cancer diagnosis who need additional diagnostic services to complete the cancer staging and to develop a treatment plan.

   *A pathology report or physician notes confirming the diagnosed cancer, and stage (if known) is required.

   Primary Site: ☐check if "unknown" _____

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Patient Last Name **First Name** **Middle Initial**

☐ Yes ☐ No The suspected or diagnosed cancer is a **RECURRENT CANCER.**

Primary Site: _____ Histologic type: _____

Approximate date of original course of treatment: ____ _____
Month/Year

Describe the proposed diagnostic workup including major imaging, biopsies or surgeries.
To your best estimation, list and describe all planned services and expected dates of completion.

A. Expected start date of diagnostic and/or staging services: ____ ____ _____
   Services must begin within 60 days of the CSA enrollment date to ensure eligibility for payment.

B. Estimated completion date (**required**): ____ ____ _____

C. List all planned diagnostic, staging and treatment planning services for which CSA funding is needed. Include all services such as imaging, biopsies or surgeries. Additional pages may be attached.

Date	Description	Date	Description

CSA enrollment for diagnostic and/or staging and treatment planning services **ends** upon completion of those services; and will end **60 days** after the CSA approval date if services have not started.

Enrollment immediately ends if the diagnosis is negative for cancer; services necessary to establish the negative cancer diagnosis will be paid.

The Medical Eligibility Form 3621T must be submitted for patients needing CSA funds for cancer treatment services. CSA approval for treatment is separate from approval for diagnostic services, and is not guaranteed. Patients, whose probability of five (5) year survival is less than 25% as supported by medical/scientific evidence, are **not eligible** for CSA funding of cancer treatment services.

Signature: _____ Date:
Your signature attests to the accuracy of the information provided