MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER HEALTH INSURANCE MEDICAL REFERRAL

CSPP # ☐☐ CSPP Client #_____

Facility/Clinic _____ Phone (___) _____

Address _____ Contact Person_____

Patient Name _____ Date of Birth_____

Patient Address_____ SSN_____

Patient Phone Number ( ) _____

Diagnosis

☐ Cervical Pre–Cancerous Lesion (if subsequent treatment is required)

☐ Cervical In Situ

☐ Cervical Invasive

☐ Atypical Ductal Hyperplasia (ADH) (if subsequent treatment is required)

☐ Breast Lobular Carcinoma In Situ (If subsequent treatment is required)

☐ Breast In Situ

☐ Breast Invasive

☐ Colorectal Pre-Cancerous (if subsequent treatment is required)

☐ Colorectal In Situ

☐ Colorectal Invasive

☐ Prostate Atypia

☐ Prostate High Grade Prostatic Intraepithelial Neoplasia (HGPIN)

☐ Prostate Invasive

Date of Diagnosis from original biopsy _____/_____/_____/
Month Day Year

Diagnosis/Staging (if available) _____

Treatment Plan _____

_____

_____

Estimated Length of Treatment (in months) _____

_____
Physician, Nurse Practitioner, or Licensed Physician Assistant (Signature) Date

_____
Physician, Nurse Practitioner, or Licensed Physician Assistant (Printed Name)

Please sign and return form to:

By_____

SECTION H APPLICANT RELEASE AGREEMENT

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I agree that the information on this medical referral may be shared only with the State Medicaid Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostrate Cancer, the Local Social Services Districts, and the Cancer Services Program Partnerships and the Cancer Services Program providing the application assistance. I understand that this information is being shared for the purpose of determining my eligibility for Medicaid. I also agree that the information released may include HIV, mental health, or alcohol and substance abuse information about me to the extent permitted by law.

_____
Print Your Full Name

_____ _____
Applicant Signature Date Witness Signature Date

DOH-4243m (4/08)