GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor | Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

Physician Statement of Treatment for Breast and/or Cervical Cancer

This form must not be **altered in any form or manner** and must be completed by the physician, or an authorized licensed medical professional of the physician (i.e. LPN, RN, NP or PA), treating the patient for breast and/or cervical cancer and designated to sign on his or her behalf. Please complete and return this form by **XX-XX-XXXX** whether the patient is currently receiving treatment for breast and/or cervical cancer or not. If we do not receive the form, we will not be able to determine continued eligibility and the Medical Assistance case will be terminated.

Patient Full Name:			
Patient DOB		**Patient SSN (if known)**	
Diagnosis (Please check)			
Breast Cancer	☐ InSitu	☐ Invasive Cancer	☐ Triple Negative
Cervical Cancer	☐ CIN II	☐ CIN III	☐ Invasive Cancer
Diagnosis Date:		**Print Name of Treating Physician**	

I certify that the above patient is in **ACTIVE** treatment for Breast and/or Cervical Cancer by checking one of the boxes that apply.

☐ **is currently in active treatment** for breast and/or cervical cancer or pre-cancerous condition and may include: surgery, radiation, chemotherapy and hormone therapy.

Must Specify Treatment:

____

____

☐ is **NOT** currently in **active** treatment for breast and/or cervical cancer.

I certify that the above information is correct regarding my patient and by signing below, I am either a Physician or an authorized Licensed Medical Professional of the physician listed above. Any **falsification** of the patient's health regarding being in treatment will result in Medicaid **fraud**, in which you may be held liable for any claims paid on the patient's behalf.

______________________________	______________	______________
Physician/Authorized Licensed Medical Professional Signature (Signature Stamp Not Acceptable)	Title	Date (Good only for 30 days)

Name of the Clinic or Office that provides the treatment: ______________________________

Address: ______________________________

Phone #: ______________________ Fax #: ______________________

The form may be submitted to www.gateway.ga.gov or womenshealth@dhs.ga.gov,

Caseworker Name		Email Address	
Telephone Number		Fax	912-377-1134
Mailing Address	RSM Group, Attn: WHM, PO Box 786 Alma, GA 31510		

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INSTRUCTIONS

In accordance with Department of Community Health (DCH) and the Georgia Department of Public Health (DPH) regulations, please follow the below direction for accurate completion of each section of the Physician's Statement of Treatment form (PST). The PST form must be completed in full and must not be altered in any form or manner.

I. **Demographics:**
   a. Must complete Patient Full Name
   b. Patient Date of Birth (DOB)
   c. Patient Social Security Number (SSN) if available

II. **Diagnosis and Certification of Treatment:**
   a. Must fill in the Diagnosis Date, the date cannot be left blank
   b. Diagnosis of Breast Cancer must be checked by indicating which type of cancer: InSitu, Invasive Cancer or Triple Negative.
   c. Diagnosis of Cervical Cancer must be checked by indicating which type of cancer: CIN II, CIN III or Invasive Cancer

III. **Provider's Information:**
   a. A physician or authorized licensed medical professional must certify if patient is in **ACTIVE** treatment for Breast and/or Cervical Cancer, explanation of what treatment or list the Medication treatment the patient is taking for treatment such as, (Tamoxifen, Arimedex, Anastrozole, Raloxifene, Toremifene, Fulestrant, Letrozole and Exemestane etc.) is considered as being in treatment for cancer.
   b. You must specify the treatment the patient is receiving.
   c. If the patient is **NOT** in active treatment the box should be checked only and no explanation is needed.
   d. The physician or the authorized licensed medical professional signature must be in its original format certifying this information is true and accurate. A stamped signature is not acceptable.
   e. The person completing this form must complete the name of the clinic, address, phone number and fax number.

Note: If any information on this form is **falsified** to assist the patient in maintaining coverage can result in Medicaid **fraud**.

***The customer was given her responsibilities regarding this renewal process and a deadline was given to the customer to have all information back to this office. Please be advised that failure to return the completed form, along with other requested information will terminate the Medicaid case of the customer listed above.**