



Florida Cancer Specialists Patient Treatment Verification Form

This form must be completed and signed by a licensed physician/oncologist or licensed PA/NP within 30 days of the application submission date.

Patient Information:

First Name: _____

Last Name: _____

Date of Birth: _____

Phone Number: _____

The section below must be completed by your physician or a licensed PA/NP.

Treatment Eligibility Criteria

- Be actively undergoing cancer treatment in Florida or within 90 days of final treatment date
- Eligible treatment is chemotherapy, radiation, immunotherapy, hormone therapy, and hematopoietic progenitor cell transplantation

Physician First Name: _____ Physician Last Name: _____

Patient Treatment Information:

Name of FCS Clinic: _____

FCS Clinic Code: _____

FCS Clinic Region: _____

Is the patient named above currently under active cancer treatment?

- Yes
- No

What is the patient's cancer diagnosis code? _____

What type of treatment is the patient receiving? Check all that apply.

- Chemotherapy
- Radiation
- Immunotherapy
- Hormone therapy
- Hematopoietic progenitor cell transplantation

If treatment is ongoing **with** no defined end date, a reevaluation date is required.

Treatment Start Date: _____

Treatment End Date: _____

Physician Signature: _____ Date: _____

Please submit completed form to Foundation@FLCancer.com or fax to (813) 623-4703

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