



**Non-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: \_\_\_\_\_

Name of treatment institute: \_\_\_\_\_

Address of treatment institute: \_\_\_\_\_

Phone number of treatment institute: \_\_\_\_\_

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: \_\_\_\_\_