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
- ☐ lmmunotherapy
- ☐ 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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