Southeastern Cancer Care
Grant Application
Treatment Verification Form
To Be Completed by a Treating Physician

*** This information is necessary to complete the patient's application ***

Patient Name: ____________________________ Patient DOB: ____________________________

Physician Name__________________________________ NPI Number ______________________

Facility/Practice Name ___________________________ Telephone______________________

City_______________________________ Fax ______________________

Office Contact Name and Number____

Patient's primary cancer diagnosis ____

Date of diagnosis____

Treatment plan (please include names of chemotherapy medication)

____

Treatment start date ____________________ Treatment length __________________

Treatment Is (circle all that apply):

Started   Paused   Discontinued   Scheduled

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of Southeastern Cancer Care's Grant Program, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Program. I understand that application to the Southeastern Cancer Care Grant Program does not guarantee financial assistance.

Physician Signature____________________________________Date__________________

Please fax the completed form to 919-429-4316 or email it to cfc@cancersmoc.com

If you have any additional questions, please contact Southeastern Cancer Care at 919-587-9056.