

**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 admin@southeasterncancercare.org.

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