NAME: _____

MEDICAL VERIFICATION FORM – TO BE COMPLETED BY REFERRING PROFESSIONAL

Do not use abbreviations codes for diagnosis or treatment. Do not send medical records. Answer each question completely.

Parent/Guardian (if patient under 18): _____

Cancer Diagnosis: _____ Stage:_____ Date of Diagnosis: _____

Describe Current Treatment: _____

Name of Physician: _____

Surgery: ☐ Date of Surgery: _____

Radiation: ☐ Begin Date: _____ Anticipated end date:_____

Hormone: ☐ Begin date: _____ Anticipated end date: _____

Patient Insurance Status: None ☐ Medicare ☐ Medicaid ☐ CICP ☐ VA ☐ Private ☐

Has the patient applied to CBCAF, Colorado Breast Cancer Awareness Foundation before? Yes NO

Is patient currently able to work? Yes No If no, when will patient be able to return to work? _____

Is patient disabled? Yes No Date of disability _____

What are the patients financial needs: ☐ Utilities ☐ Medical ☐ Transportation ☐ Rent ☐ Food

☐ Mortgage ☐ Financial Assistance ☐ Other: _____

****For Application to be eligible, we must have the following contact information****

Name of referring professional (health care professional filling out form): _____

Facility Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Email: _____

Do you have any reservations concerning this patients request for financial assistance? Yes No

Referring professionals summary regarding the patients need for financial assistance: Required

_____

_____

_____

_____

My signature below affirms the diagnosis and treatment information described on this page

Signature _____ Date _____