Physician Verification Form
Co-Payment Assistance

275 Seventh Avenue, 22nd Floor, New York, NY 10001
866-55-COPAY (866-552-6729)
Fax: 212-601-9760

Dear Physician,

Your patient has applied for enrollment to Cancer*Care* for co-payment assistance. In order to complete the enrollment process, we must verify the following information with you as the prescribing and/or treating physician. You may either return the form back to us in the envelope provided or fax to number listed above. Please contact the Co-Pay Foundation with any questions that you may have about this form.

First Name ________________________ Last Name ________________________

Address ____

City ________________________ State ____________ Zip Code ______________

Diagnosis: ◯ Breast ◯ Colorectal ◯ Lung ◯ Pancreatic Dx Date ______________

Stage ____________________________ ICD-9 Code ________________________

Prescribing Physician

First Name ________________________ Last Name ________________________

Tax ID # ______________ License # ________________ DEA # ______________

Address ____ Suite ______________

City ________________________ State ____________ Zip Code ______________

Phone (   ) ____________________ Fax (   ) ____________________

Contact Person ____________________________ Position ____________________

Phone (if different from above) (   ) ____________________

Chemotherapy Medication(s) that have been or will be prescribed as indicated for your patient's cancer type

Medication Name	Dosage/Frequency	Expected Length of Treatment

I understand that the Cancer*Care* Co-Payment Foundation provides assistance to eligible patients for medications covered in the above mentioned diagnosis categories. While the Foundation will make every effort to grant assistance when needed, the program is limited by available resources and may be discontinued or changed at any time. I further certify that the medication(s) listed above have been or will be prescribed and I will be overseeing the patient's treatment accordingly.

Physician's Printed Name: ____

Physician's Signature: ________________________________ Date______________

SAMPLE