CancerCare Co-Payment Assistance Foundation

Dear Doctor,

The Cancer*Care* Co-Payment Assistance Foundation (CCAF) is a nonprofit organization dedicated to helping patients afford their co-payments for chemotherapy and targeted treatment drugs. We provide this assistance to ensure access to care and compliance with prescribed treatments. To be eligible, patients must meet certain financial and medical criteria related to their diagnosis and treatment. The primary diagnosis for the patient must match our fund definition and the medication prescribed must be to treat the primary diagnosis.

Your patient has already enrolled in our program and was approved based on our initial assessment with the patient or his/her advocate. However, as part of our ongoing compliance requirements, the patient's diagnosis must be verified by the treating physician.

As the treating physician, please complete and sign the form below. **Completed forms can be faxed to our office at 212-601-9760, emailed to information@cancercarecopay.org or uploaded to the patient account via our secure *Patients & Pro's portal* at portal.cancercarecopay.org.**

I certify that I am the treating physician for _____ _____
Patient Name **Date of Birth**

The patient's primary cancer diagnosis is _____ _____
Diagnosis **ICD-10**

_____
Date of Diagnosis **Please Specify:** **Metastatic ____** **Non-Metastatic ____**

Disease Subtype as applicable _____

Lung Cancer – Please Specify: **Non-Small Cell Lung _____** **Small Cell Lung _____**

Thyroid Cancer – Please Specify: **Follicular ____** **Hurthle ____** **Papillary____**

I further certify that the above named patient is **currently undergoing active treatment with chemotherapy and/or targeted treatment medications to treat his/her primary cancer** and I will be overseeing the patient's treatment accordingly.

Medication Name	**Treatment Plan**	**Expected Length of Treatment**

Prescribing Physician

First Name _____ Last Name _____

Address _____ _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

NPI # _____ Office Contact _____

Physician's Signature: _____ **Date**_____