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 complete an enrollment form and meet the financial, medical and insurance criteria related to their diagnosis and treatment. The primary cancer diagnosis for the patient must match our fund definition and the medication prescribed must be to treat the primary diagnosis. **This is NOT the enrollment form. This is only the physician's verification form which is part of the enrollment process. If you did not already enroll your patient please go to https://www.cancercare.org/copayfoundation and review the fund status and eligibility criteria.**

As the treating physician, please complete, sign and return this form. **Completed forms can be uploaded to the patient account directly through our secure CoPay Connect™ patient portal at https://portal.copayconnect.org, faxed to 212-601-9760 or email to information@cancercarecopay.org.**

Once received, a Co-Payment Specialist will review and update the patient account. **Please allow 10 to 15 business days for review**. Through our **CoPay Connect™** patient portal you can check the status of the grant and physician's verification form.

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 Circle: Metastatic Disease Yes / No

Disease Subtype as applicable: _____

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

I further certify that the above-named patient is **currently undergoing active treatment with chemotherapy and/or targeted treatment medications to treat their 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:** _____