Diagnosis Verification

In order to assist your patient, we need to verify his/her diagnosis. Please complete, SIGN (required), and UPLOAD this form through the PORTAL or fax it to:

SECTION 1: PRESCRIBING PROVIDER INFORMATION

Prescribing Provider Name, Credentials: _____

Facility Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Fax:** _____

Email: _____

Who is the **Primary Office Contact** for this application? (social worker, nurse)

First and last name **REQUIRED** _____

Primary Contact Telephone: _____ **Primary Contact Fax:** _____

SECTION 2: PATIENT INFORMATION

My patient, _____, is being treated for_____

Diagnosis/ICD-10 code: _____

Date of Birth: _____ Last 4 digits of SSN: _____

By signing this Diagnosis Verification, **I hereby certify (I) that I'm duly licensed and authorized in my state, that the diagnosis listed above is accurate, and that I will be supervising the patient's treatment accordingly.**

By signing this Diagnosis Verification, I hereby understand that:

- The Field House Cancer Foundation offers assistance to eligible patients for monthly household expenses.
- While the Foundation will make every effort to grant assistance when needed, the Foundation's program is limited by available resources and may be discontinued or changed at any time; and
- Any identified patterns of inappropriate submissions to the Foundation may result in my-or the entity I represent- termination from the Foundation's program for a length of time determined by the Foundation.

PLEASE NOTE: A patient is free to change his/her physician at any time, and this will not affect his/her enrollment.

X_____ **DATE:**_____

Prescriber's Original Signature (STAMPED OR ELECTRONIC SIGNATURES NOT VALID) **(IF UNDATED, FIELD HOUSE CANCER FOUNDATION, WILL**

DEEM THE DATE-OF- SUBMISSION AS THE DAY OF PROCESSING)

X_____

PRINTED Prescriber's Name & Credentials-REQUIRED (example: MD, DO, NP, PA)