Physician Verification Form
Breast Cancer Financial Assistance Program

PO Box 1770, Leland, NC 28451
info@GoingBeyondthePink.org
910-667-2111

Date:

Dear Physician or Health Care Professional,

Your patient has applied for financial assistance for breast cancer related medical costs. 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 your patient or mail/email it to the address indicated above. Please contact *Going Beyond the Pink* with any questions that you may have about this form.

Step 1 – Patient Information

First Name_____ Last Name _____

Address _____

City_____ State_____ Zip Code _____

Diagnosis – Breast Cancer DATE of Breast Cancer Diagnosis _____

Step 2 – Health Care Professional Contact for Patient

PHYSICIAN'S First Name_____ PHYSICIAN'S Last Name _____

Address_____ Suite _____

City_____ State_____ Zip Code _____

Phone ( )_____ Fax ( ) _____

Other Contact Person_____ Position _____

Phone (if different) ( )_____ Email Address _____

I certify that the patient named above has been diagnosed with Breast Cancer, is under my care for the treatment of such diagnosis and it is expected that medical costs are anticipated during the upcoming twelve-month period for the treatment of breast cancer.

Physician Signature:_____ Date:_____