

Statement of Medical Necessity for Febrile Neutropenia Therapy

Patient Information	Patient Name	Date of Birth		
	Address	Relationship to Policyholder		
	City	State	Zip	
	Phone (H) ()	Phone (W) ()		
Insurance Information	Primary Policyholder Name	SSN		
	Insurance Company	Policy #	Group #	
	Claim Address	City	State	Zip
	Phone ()			
Diagnosis* (Include all that apply)				
Medical Assessment	Patient Weight	Other		
	CBC (date and levels)	Other		
	ANC (date and level)	Other		
	Hct or Hgb (date and levels)			
	Platelet (date and level)			
Recommended Treatment	Product Description			
	Therapy Initiation	Dose		
	Maintenance Therapy	Frequency		
	Therapy Start Date	Estimated Length of Therapy (if applicable)		
	Planned Follow-up/Evaluation Frequency (if applicable)			
	Notes			
	Attachments			
Physician Certification	<i>I certify the above therapy is medically necessary and that this information is accurate to the best of my knowledge.</i>			
	Physician Signature	Date		
	Print Physician Name			
	Address	Tax ID#		
	Phone ()	City	State	Zip

* Physicians are responsible for entering the appropriate diagnosis code corresponding to the individual patient's actual diagnosis.