



## Statement of Medical Necessity for Therapy of Metastatic Carcinoma of the Colon or Rectum

<b>Patient Information</b>	Patient Name	Date of Birth
	Address	Relationship to Policyholder
	City	State ZIP
	Phone (H) ( )	Phone (W) ( )
<b>Insurance Information</b>	Primary Policyholder Name	SSN
	Insurance Company	Policy # Group #
	Claim Address	City State ZIP
	Phone ( )	
<b>Diagnosis Code*</b> (Include all that apply)		
<b>Medical Assessment</b>	Patient Weight	Other
	Previous chemotherapy regimen (date and outcome)	
	Previous chemotherapy regimen (date and outcome)	
<b>Recommended Treatment</b>	Product Description	
	Therapy Initiation	Frequency
	Therapy Start Date	Estimated Length of Therapy (if applicable)
	Dose	
	Planned Follow-up/Evaluation Frequency (if applicable)	
	Notes	
	Attachments	
<b>Physician Certification</b>	<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.