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TREATMENT PLAN
FOR CHEMOTHERAPY / RADIOTHERAPY

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient		Sex
Date of Birth (MM/DD/YY)	Member No.	Policy No.
If group insurance, name of the Policyholder		

SECTION B – TREATMENT PLAN RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis
Does the patient need Chemotherapy / Radiotherapy? (Please circle) *Yes* ☐ *No* ☐
Duration of treatment
Scheduled dates of treatment
Number of chemotherapy cycles / radiation sessions required
Name and dosage of prescribed medicine (if applicable)
Frequency and route of administration
Please specify length of stay if treatment is received on inpatient basis
Estimated itemized cost for each chemotherapy cycle / radiation session including hospital expenses and professional fees

Name of Attending Physician: _____

Address: _____

_____

_____

Telephone No.: _____

Email: _____

_____
Signature of Attending Physician with Stamp

Date: _____