CancerCARE
Right Care. Right Time. Right Place.

CANCERCARE REFERRAL				
MEMBER INFORMATION				
TPA/Health Plan:			Group:	
Member:	☐ M ☐ F		Date of birth:	Address:
Phone(s):			Email:	
Diagnosis:			Stage:	Date of diagnosis:
☐ Insured ☐ Dependent	Insured's Name:			Insured ID:

	PROVIDERS	
☐	PCP:	Address/Phone:
	ONCOLOGIST:	Address/Phone:
	SURGEON:	Address/Phone:
	RAD ONC:	Address/Phone:
	FACILITY:	Address/Phone:
	TREATMENTS	
☐	Recent Treatment Request(s):	
	Recent Treatment Approval(s):	
	Known Treatment History:	
	CASE MANAGER	
☐	Referred by (company):	Date:
	Referred by (contact):	Phone:
	Additional Information:	
	OTHER NOTIFICATION/ADDITIONAL INFORMATION	
☐		

Form completed by:	Phone:	Date:

Please securely email or fax completed information to CancerCARE at: cancermanagement@cancercareprogram.com or 503.640.6277

Please include any medical records you have for this member.