PACIFIC CROSS VIETNAM

The strength behind your insurance

TREATMENT PLAN FOR CHEMOTHERAPY/RADIOTHERAPY

(All sections must be completed)

PART 1: GENERAL INFORMATION

Insured name: _____ Member No.: _____

DOB & age: _____ Gender: _____

PART 2: TREATMENT DETAILS

Please circle: ❑ **CHEMOTHERAPY** ❑ **RADIOTHERAPY**

1. Diagnosis:

_____

_____

2. The duration of the whole treatment:

_____

_____

3. Please provide the schedule dates of treatment:

_____

_____

4. The number of cycles/radiation required:

_____

_____

5. The medicine and dosage used (if applicable):

_____

_____

6. Please specify whether it is done on Outpatient or Inpatient basis. For Inpatient, please specific the estimate length of stay:

_____

_____

_____

7. Estimate cost for each cycle/radiation including hospitalization & Professionals' fee:

_____

_____

_____

Name of Attending Physician: _____

Address: _____

_____

Tel: _____

E-mail: _____

_____

Signature of Attending Physician with stamp

Date (day/ month/ year): _____