

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 specify 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): _____