Cancer Connection
Counseling Reimbursement Program
PO Box 20329
Juneau, AK 99802
(907) 796-2273

Counseling Reimbursement Form

Patient Data

Patient Information (please print):

Name ______________________ Phone ______________________

Mailing Address ______________________ Age ______________________

City ______________________ State ______________________ Zip ______________________

Email Address ______________________

Physician ______________________ Insurance Company ______________________

I hereby authorize my physician to release my diagnosis, or medical information related to my diagnosis, to Cancer Connection for the purpose of establishing eligibility for travel assistance. I understand this authorization is voluntary.

Assistance Required (to be completed by Health Care Provider):

Patient would benefit from counseling for cancer-related issues.

Certification of Physician

This patient has a positive diagnosis of: ______________________
Designation of Cancer

The purpose of this request is for counseling assistance in the treatment of cancer.

Date: ______________ Physician's Signature: ______________________

Please fax completed form to Cancer Connection at (907) 463-2616.

Eligibility (to be completed by a volunteer from Cancer Connection):

I hereby certify that this patient is eligible for the assistance requested under the terms of the policies.

Date: ______________ Volunteer's Signature: ______________________