FIRST OCCURRENCE BENEFIT FORM

Patient's Name: ______________________________ Policy #: ____________________

Section II: PHYSICIAN'S STATEMENT (to be completed by Physician's Office)

Physician Name: ______________________________ Specialty: ____________________

Address and Phone Number: ____

INITIAL CANCER CLAIMS:

1. When was cancer of **any** type first diagnosed? ____________ Diagnosis Code(s): ____________
2. Was the most recent cancer diagnosis made from a surgical biopsy? ☐ YES ☐ NO

   Please provide CPT procedure code(s) used to diagnose this cancer. ____________________
3. What type of cancer was diagnosed? ____________________________________
4. When was the patient first consulted for this condition? ____________________
5. Has the patient ever been diagnosed with AIDS/ARC? ☐ YES ☐ NO If YES, when? ____________
6. Do you have records on the patient's past medical history? ☐ YES ☐ NO

   If NO, please list family physician: ______________________________

Physician's Signature:______________________________ **Date:** ____________________

FORM C15FOB1ST