LEUKEMIA & LYMPHOMA SOCIETY®

The LLS Scholarship for Blood Cancer Survivors

YOUR FUTURE IS NOW

Patient Diagnosis Verification Form

To be completed by the physician.
Please upload the completed form to the Scholarship Application Portal.

Patient Name: _____ **Date of Birth:** _____

Patient Diagnosis Information *(All fields **must** be completed by the Physician)*

Does the patient have a confirmed blood cancer diagnosis? ☐ Yes ☐ No

Please select the patient's primary disease category

☐ Leukemia ☐ Lymphoma ☐ Myeloma ☐ Myelodysplastic syndrome ☐ Myeloproliferative Neoplasms

Diagnosis Name: _____

ICD10 Code: _____ Initial Diagnosis Date: _____

Physician Information *(All fields **must** be completed)*

Physician Name: _____ NPI #: _____

Physician Specialty: ☐ Oncologist ☐ Hematologist ☐ Primary Care Physician ☐ Other

Facility/Practice Name: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Office Contact Name: _____ E-mail: _____

I attest that the information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of The Leukemia & Lymphoma Society's Scholarship for Blood Cancer Survivors program, its representatives, and/or agents selected in order to assess the patient's eligibility for participation in the program. I understand that this assistance is temporary and that the patient may be asked to reapply at designated intervals.

Physician's Signature: _____ Date: _____