BENEFITS INVESTIGATION ASSESSMENT

|  |  |  |
| --- | --- | --- |
| **Patient Name** |  |  |
| **Group Number** |  |  |
| **Effective Date** |  |  |
| **Insurer** |  |  |
| **Insurer Phone #** |  |  |
| **Insurer Website** |  |  |
| **Deductibles** |  |  |
| **Co-pay Amount (office visits, etc.)** |  |  |
| **Co-Insurance** |  |  |
| **Out-of-Pocket-Maximum** |  |  |
| **Lifetime Maximum** |  |  |
| **Authorizations (Y/N):** |  |  |
|  | **Scans** |  |
|  |  | **MRI** |
|  |  | **CT** |
|  |  | **PET** |
|  | **Chemotherapy** |  |
|  | **Radiation** |  |
|  |  | **IMRT** |
|  |  | **IGRT** |
| **Pharmacy Benefits** |  |  |
| **Phone Number for Pharmacy Benefits** |  |  |
| **Deductible** |  |  |
| **Co-pay** |  |  |
| **Yearly Maximum** |  |  |
| **Lifetime Maximum** |  |  |



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