Medical certification

Provider name: _____

Patient name: _____

_____ (Patient name) is a patient of this medical office/mine, who is being treated for _____. I _____, have determined that, _____ (patient name) is in need of genetic testing to determine if there is a genetic cause of her cancer. The test that we recommend is _____.

This patient does/does not have applicable medical insurance coverage. The patient will have to incur out-of-pocket expenses for the testing because (insurance will not cover the testing/insurance deductible/co-insurance). We have determined that the lowest out-pocket-cost for this testing would be _____.

We believe, based on our interactions with this patient, that this expense would create a financial burden for this patient.

We submit this request on behalf of, and with the full consent of, the patient.

Patient Signature: _____ Date: _____

Printed patient name: _____

Provider Signature: _____ Date: _____