PATIENT APPLICATION FOR FINANCIAL ASSISTANCE

Please send completed form with the test requisition
OR fax it at the time of sample collection to 1-855-647-4363

Today's date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Married / Divorced/ Separated / Widowed	
Birth date: / /	Age	Sex ❑ M ❑ F	Best time to contact you:		Best contact no.: ( )	
Street address:			Social Security no.:		Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	

FINANCIAL INFORMATION	
Current annual household gross income	**$**
Number of household members dependent on the income stated above (including the applicant)	

In order to be considered for this program, the following documents must be supplied:

☐ This application form completed and **SIGNED**

☐ A copy of your most recent tax return and/or the past 2 years W-2's for all wage earners

☐ Copy of any information provided by your insurance company related to the reimbursement of myGenomics Hereditary Testing Panel

APPLICATION DECLARATION

I attest that the information provided is complete and accurate. I agree that at any time during my enrollment myGenomics, LLC may request additional documents to authenticate the statements made on my application. I understand that myGenomics reserves the right to change or discontinue this program at any time.

Patient/Guardian Signature *Date*