PATIENT FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION	
Account Number**:**	
Patient Last Name, First Name:	
Guardian's Full Name:	Relationship to Patient:
Patient Address:	City: State: Zip:
Phone Number:	Email Address:
Date of Birth:	Preferred method of contact: [ ] Phone [ ] Email [ ] Mail
Patient's annual gross household/family units income: Family Units:_____ $ _____	Please provide ***one*** of the following forms of documentation: • The first page of your most recent federal tax return (Form 1040), or • Recent paycheck stub for each wage earner in your household/family unit, or • Other evidence of your household/family unit income

CERTIFICATIONS

- The information submitted and provided for this application is complete and accurate.
- I understand that completion of this form does not guarantee financial assistance.
- I certify that paying for the NeoGenomics testing would cause financial hardship.
- I understand that this program is subject to change or termination by NeoGenomics.

AUTHORIZATIONS

- I authorize NeoGenomics to use the information on this application to assess my eligibility for the NeoGenomics financial assistance program.
- I authorize NeoGenomics to contact me directly regarding this application.
- I understand that these authorizations, which are required for participation in this program, can be canceled at any time by mailing a letter to NeoGenomics.

I certify that I have read and understand the Certifications and Authorizations above and that I agree to the above terms, as indicated by signing below:

Patient's Signature:	Date Signed (required):
Guarantor's Signature:	Date Signed (required):
FOR BILLING DEPARTMENT USE ONLY	% of Assistance:
Approved by:	Date:

Mail Application to:
NeoGenomics Laboratories, Inc.
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