Financial Assistance Program

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AlphaGenomix.com

ALPHA GENOMIX WILL BE PERFORMING LABORATORY TEST(S) at the request of your physician. Alpha Genomix Laboratories has a set Financial Assistance Program (FAP). Patient requiring financial assistance will need to complete the form within 60 days of services.

The patient will need to complete the financial disclosure form and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1. W-2 withholding statements
2. Pay check stubs
3. Income tax return
4. Forms from Medicaid or other state-funded medical assistance

If it is determined the patient does not qualify for financial hardship after submitting the Financial Disclosure Form, the fee will NOT be adjusted.

Alpha Genomix - Billing Department
phone 1-888-234-4920

patient name | phone # | date of birth

address | city | state | zip

statement dates required

FINANCIAL INFORMATION

Please complete the requested information below. All information provided is strictly confidential and will be used only for purposes of determining financial hardship. Please provide as much information as possible for Alpha Genomix to consider when making its hardship determination.

1. Does the patient have health insurance? ___ Yes ___ No (If "Yes," please attach a copy of your insurance card.)
   - 1a. Do you receive assistance from Medicaid? ___ Yes ___ No
   - 1b. Do you receive assistance from Medicare? ___ Yes ___ No
2. Individual income (Salary, Social Security, Disability - obtain from your pay stub): $_____
3. How many people live in your household including your spouse? _____

I hereby acknowledge that the above information is true and correct. I authorize Alpha Genomix to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request. I understand that if I do not qualify, I will be

notified and Alpha Genomix will bill me. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing. Any information obtained will be used to determine eligibility for financial assistance.

Responsible Party Name (please print) Responsible party signature Today's Date

INTERNAL USE ONLY

DOS	Owed Amount	Adjusted Amount	Denial Reason
Date Processed	Date Received:	Processor Name	

Billing representative name Date