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
$ Patient's annual gross household/family units income	Family units

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 becanceled 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)

Mail Application to:
NeoGenomics Laboratories, Inc.
P.O. Box 947586, Atlanta, GA 30394-7586
Phn: 866.776.5907 **Fax:** 239.690.4237

FOR BILLING DEPARTMENT USE ONLY

Approved by:

Date:

% of assistance: