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 the first two pages of senior tax return (Form 1040-SR)
- Three recent paychecks stubs of 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)

Mail Application to:
NeoGenomics Laboratories, Inc.
P.O. Box 947586, Atlanta, GA 30394-7586
Phn: 866.776.5907 **Fax:** 844.560.3058

FOR BILLING DEPARTMENT USE ONLY
Approved by: **Date:**
% of assistance: