Financial Assistance Application

Patient Information

Patient Name _____

Street Address _____

City _____ State _____

Postal Code _____ Country _____

Phone _____

Date of Birth (mm/dd/yyyy) _____

Date of Service (mm/dd/yyyy) _____

Acession number _____

Do you receive any government benefits, such as Medicare and/or Medicaid? ☐ Yes ☐ No

Number of people in your household _____

Last year's taxable income (Line 22 of IRS form 1040) $_____

Razor Genomics, Inc. may request proof of income prior to approving your application for Financial Assistance. The Razor Genomics, Inc. Financial Assistance program is based on the current years Federal Poverty Guidelines published at https://www.hrsa.gov/get-health-care/affordable/hill-burton/poverty-guidelines.html.

Submittal Information

Please initial the following statements:

_____ I certify that the information contained in this application is complete and correct to the best of my knowledge.

_____ I certify that I will provide proof of income within 15 days should it be requested.

_____ Date Signed _____

Patient Signature

_____

Printed Patient Name

Please submit your completed and signed application form via fax or mail:

Mail:
Razor Genomics, Inc.
DEPT 0337
PO Box 120337
Dallas TX 75312-0337

Fax:
[1-844-662-6298]

Razor Genomics, Inc. will send a notification letter indicating your eligibility determination. An incomplete form may result in delays to processing your application.

Internal Use only:

Information Received Verbally by _____ Date Received _____

_____ Qualified % _____ _____ Not Qualified

Date Sent to Billing_____

For any questions please contact the Oncocyte Customer Service Team at +1-844-ONCOCYTE [1-844-662-6298] or customer.service@oncocyte.com.