VitaGraft Kidney™
Personalized Transplant Monitoring

Financial Assistance Application

Customer Service Phone/Fax
1-844-621-8880

Customer Service Fax
1-844-584-3467

Customer Email
customer.service@oncocyte.com

Patient Information

Patient Name: First _____ Middle Initial _____ Last _____ Suffix _____

Street Address _____

City _____ State Postal Code _____

Country _____ Phone _____

Date of Birth (mm/dd/yyyy) _____ Gender _____

Date of Service (mm/dd/yyyy) _____ Accession number _____

Primary Insurance Subscriber Name _____

Relationship to Subscriber _____

Name of Primary Insurance Plan _____

Primary Insurance ID/Group No. _____

Secondary Insurance Subscriber Name _____

Relationship to Subscriber _____

Name of Secondary Insurance Plan _____

Secondary Insurance ID/Group No. _____

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) $ _____

Diagnosis _____

Date of Transplant _____

Oncocyte Corporation may request proof of income prior to approving your application for Financial Assistance. Oncocyte Corporation's Financial Assistance program is based on the current years Federal Poverty Guidelines published at:
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

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.

Patient Signature _____ Date Signed _____

Printed Patient Name _____

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

Mail: Oncocyte Corporation
DEPT 0293
PO Box 120293
Dallas, TX 75312-0293

Phone: 844-679-6600
Fax: 949-271-4972

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

Internal Use only:

Qualified _____ % _____ Not Qualified _____ Date Sent to Billing _____

Information Received Verbally by _____ Date Received _____

For any questions please contact the Oncocyte Customer Service Team at
1-844-621-8880 or Oncocyte Billing at 1-844-679-6600 or customer.service@oncocyte.com

ONCOCYTE™