DETERMA Rx™

Financial Assistance Application

www.oncocyte.com
customer.service@oncocyte.com

Customer Service Phone/Fax
1-844-ONCOCYTE (1-844-662-6298)

Customer Service Fax
1-800-406-5189

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)

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://www.hrsa.gov/get-health-care/affordable/hill-burton/poverty-guidelines.htm.**

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:

Information Received Verbally by _____ Date Received _____

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

For any questions please contact the Oncocyte Customer Service Team at 1-844-662-6298 or Oncocyte Billing at 1-844-679-6600 or customer.service@oncocyte.com

ONCOCYTE™