Patient Financial Assistance Application

Financial Assistance is available to domestic residents of the US.
Please fax to: +1 617.830.0279 Email: client.services@foundationmedicine.com

*Required Information

For more information or to file your application online, visit: aid.foundationmedicine.com

Patient Information

*Last Name

*First Name MI

*DOB (MM/DD/YYYY) *Sex ☐ F ☐ M

*Street Address Apt. # *City

*State *Postal Code *Country

*Phone ☐ I authorize Foundation Medicine to leave a detailed voicemail at this phone number

Email

*Total Gross Annual Household Income

Estimated Gross Annual Household Income
(Current income. Estimated ranges not accepted.)

☐ Number of family members in household supported by above gross annual household income (including patient)
Must be filled out to process form

*Who Should We Contact with the Approval Decision?

Ensure contact information for patient and facility is filled in at the top of the form.

Check all that apply: Preferred method of contact: (select one)

☐ Patient ☐ Email ☐ Phone ☐ Mail

☐ Practice ☐ Email ☐ Fax

*Ordering Physician and Facility Information

Office/Practice/Facility Name

Ordering Physician

Phone

Fax

Email

Extenuating Circumstances

Please advise of any extenuating circumstance that you would like us to consider.

☐ Retired (i.e., fixed income)
☐ Short or long-term disability
☐ Significant credit card debt
☐ Significant medical expenses
☐ Supporting family member(s) outside of household
☐ Alimony and/or child support
☐ Loss of income due to diagnosis or treatment (if both please explain)
☐ Temporary ☐ Permanent
☐ Unforeseen expenses (e.g., home or car repair, etc.)
☐ Non-local travel expenses for treatment (e.g., hotel, airfare, etc.)
☐ College expenses for child/children
☐ Other (Please attach additional detail)
☐ None

*I Hereby Acknowledge the Above Information is True and Correct:

Patient Name OR Representative (Print)

Signature (Required)

Relationship to Patient

Date

As a Representative of the patient, or an Ordering Physician completing this application on the patient's behalf, my signature certifies that I have explained to the patient the nature and purpose of this application and that the patient has consented to my completing the application on his/her behalf. My signature also indicates that, at the time of application, the patient named above was unable to sign this form, and that, should an authorized personal representative have been appointed, no such authorized personal representative was available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility or liability for the services rendered.

Return Signed Form to Attn: Client Services

Fax: 617.830.0279

Email: client.services@foundationmedicine.com

For patients with health insurance, the insurance provider will be billed first. Your qualified amount for financial assistance will be applied to any unpaid balance remaining after billing insurance.

FOUNDATION MEDICINE®