Ambry Genetics®
A TEMPUS COMPANY

Financial Assistance Program Application

If you would prefer to fill this form out online, scan the QR Code or go to ambrygen.com/FAP

Phone: 949.900.5500 | Fax: 949.900.5501
billing@ambrygen.com

Complete all fields below. We will process your request and notify you of your eligibility. An incomplete request will delay processing.

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Sex Assigned at Birth
			☐ Female ☐ Male

Address	City	State	Zip

Email Address	Mobile Phone Number

TESTING INFORMATION

Ordering Healthcare Provider's Name	Institution or Practice/Office Name

Testing Ordered

☐ Cancer Risk ☐ Exome or Neurology ☐ Heart/Cardiology ☐ Other: _____

INSURANCE AND INCOME

Do you have healthcare insurance?	☐ Yes ☐ No

Annual household income before taxes:*	Number of people supported by that income including parent:

Extenuating Circumstances:

☐ Alimony and/or child support expenses > $1,000 per month	☐ Currently enrolled in short- or long-term disability with my employer	☐ None
☐ Non-local travel for treatment (e.g., hotel, airfare) > $1,000	☐ Credit card debt > $5,000	☐ Other: _____
☐ Supporting family member(s) outside of household	☐ Medical expense > $5,000	
☐ Qualified for charity care with my physician	☐ Permanent loss of income due to diagnosis or treatment	

Please share any additional background you would like the billing support team to consider:

* Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Other Income

CONSENT TO APPLICATION

☐ Patient

I hereby acknowledge the above information is true and correct. I authorize Ambry Genetics (Ambry) to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request. I understand that if I do not qualify, I will be notified and Ambry will bill me. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing. I understand and agree that Ambry reserves the right at any time and without notice to modify the application form; to modify or terminate this program; and to audit the information I have provided on this application. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, government program or other source of financial assistance.

☐ Patient Representative

As a Personal Representative of the patient, my signature certifies that (1) I have the right to do so on the patient's behalf, (2) if possible, I've explained to the patient the nature and purpose of this application, (3) the information set forth above is, to the best of my knowledge, truthful and complete, and (4) I consent to Ambry's use of the information to assess and/or verify eligibility for assistance.

Print Full Name	Phone

Relationship to Patient	Email

Signature	Today's Date

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