

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



Financial Assistance Program Application

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

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 suppo		rted by that income including parent:	
Extenuating Circumstances:				
Alimony and/or child support expenses >	nort- or long-term	None		
\$1,000 per month disability with my emp		loyer	Other:	
Non-local travel for treatment (e.g., hotel, airfare) > \$1,000	Credit card debt > \$5,			
Supporting family member(s) outside of	treatment loss of income due to diagnosis or			
household				
Qualified for charity care with my physician Please share any additional background you would like the billing support team to consider:				
Trease 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	
		E 1		
Relationship to Patient Email				
Signature			Today's Da	ite