Patient Financial Assistance Program Application

Your treating physician requested that Oncimmune (USA) LLC perform the EarlyCDT as part of your care. WE understand that paying for medical care can be difficult and may present an undue hardship to some patients. As part of our ongoing commitment to patient care, Oncimmune strives to work with patients in a way that is fair and sensitive to your individual circumstances to help you to address the financial responsibilities to Oncimmune (USA) LLC.

The Oncimmune Patient Care Program assists qualifying patients to afford our testing services. To qualify, a patient must either (a) have experienced or currently be facing a financial hardship that prevents obtaining insurance coverage: or (b) have a household income that falls below 400% of the U.S. Department of Health and Human Services Poverty Level.

If you choose to apply, you must fully complete and return this application (with the documents indicated) to Oncimmune (USA) LLC. Once you have applied, we request that you make no payments until you receive notification from us regarding the status of your application. If you have any questions, please contact Oncimmune (USA) LLC at 888-583-9030.

Please complete the attached Patient Financial Assistance Program Application and fax it to 913-583-9001 or mail to:

Oncimmune (USA) LLC
8960 Commerce Drive, Bldg 6.
De Soto, KS 66018

Patient Information

Last Name First Name MI _______________________________	Phone Number _______________________________
Address _______________________________	Date of Birth ________________
City State Zip _______________________________	Do you have medical insurance coverage □ Yes □ No

Financial Information

Current annual household gross income $___________

Number of household members dependent on the income stated above (including the applicant) ___________

The following documents must be provided upon request by Oncimmune (USA) LLC.

□ Copy of your most recent tax return or the past 2 years W-2's for all wage earners in your household.

I HEREBY ATTESTS THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT ONCIMMUNE (USA) LLC MAY REQUEST EVIDENCE TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING WHETHER I QUALIFY FOR THE ONCIMMUNE (USA) LLC PATIENT FINANCIAL ASSISTANCE PROGRAM, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING

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Responsible Party Name (Print) **Responsible Party Signature** **Date(mm/dd/yyyy)**