BAYLOR GENETICS

BAYLOR GENETICS
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PATIENT ASSISTANCE PROGRAM & APPLICATION

After careful review, your healthcare provider determined that genetic testing by Baylor Genetics Laboratories is necessary. Baylor Genetics abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Baylor Genetics recognizes that circumstances may arise where an individual is unable to pay. We adopted a process of screening requests for delayed payment plans, discounts, or forgiveness of debt based on individual circumstances. This patient assistance program is our committment to work with patients and assure that necessary genetic testing can be provided at a reasonable cost for those with a financial need or for those who are under insured. Baylor Genetics will calculate your financial need based on your annual adjusted gross income and the number of family members in your household.

PROGRAM REQUIREMENTS

If you meet the following criteria, please complete this form and provide supporting documentation.

● Patient has healthcare insurance, received a bill, and needs financial assistance.

Patients with U.S. federal or state funded heath insurance (Medicare, Medicaid) should not use this form.

FAMILY SIZE (EXCLUDING CURRENT PREGNANCY)	COMBINED FAMILY INCOME EQUAL TO OR LESS THAN*
1	$48,240
2	$64, 960
3	$81,680
4	$98,400
5	$115,120
6	$131,840
7	$148,560
8+	$165,280

PATIENT INFORMATION

Patient Last Name

Patient First Name _____ MI

_____ / _____ / _____
Date of Birth (MM / DD / YYYY)

Address

City _____ State _____ Zip _____

E-mail

Primary Insurance Company Name

Total Annual Gross Household Income _____ Number in Household _____

Test Code Ordered

* Patient assistance is based on the Federal Poverty Income Sliding Scale. Combined household income must be less than or equal to four times the federal poverty guidelines. This is based on the HHS Poverty Guidelines. Restrictions may apply.

ATTESTATION

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Baylor Genetics Patient Assistance Program requirements. I understand and agree that Baylor Genetics reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to verify the information I provide 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. I understand that if I do not qualify, I will be notified. I acknowledge that I am neither related to, nor employed by, the healthcare provider ordering the genetic tests. Baylor Genetics can require the patient to pay full price if it later determines that inaccurate information was provided.

Signature of Patient or Legal Representative _____ _____ / _____ / _____
Date (MM / DD / YYYY)

EXAMPLES OF SUPPORTING DOCUMENTATION

- Copy of Most Recent IRS 1040 Tax Form
- Earnings From Work - Last 2 Paycheck Stubs
- Unemployment Payment Information
- Social Security Disability or Survivor Benefits
- Child Support Statement
- Proof of Bankruptcy Settlement
- Catastrophic Situations (Death or Disability)
- Other Documentation Showing Inability to Pay

OFFICE USE ONLY

○ APPROVED ○ DENIED _____ Initial _____ / _____ / _____ Date (MM / DD / YYYY)