Patient Financial Assistance Application

Financial assistance is available for patients whose tests were ordered within the US and US territories.
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 ☐ Prefer not to disclose

*Home 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 & Family Size

Please list current gross annual household income (estimated ranges not accepted).

Please include number of family members in household supported by above gross annual household income (including patient). This number must be included 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:
☐ Patient
☐ Practice

Preferred method of contact: (select one)
☐ Email ☐ Phone ☐ Mail
☐ Email ☐ Fax

Ordering Physician and Facility Information

*Office/Practice/Facility Name

*Ordering Physician

Phone

Fax

Email

Facility Address

Extenuating Circumstances

Please advise of any extenuating circumstances you would like us to consider:

☐ Significant medical expenses, including non-local travel expenses for treatment (e.g. hotel, airfare, etc.), that exceed 10% of total gross annual household income.

☐ Significant credit card debt or unforeseen significant expenses (e.g. home or car repair) that exceed 10% of total gross annual household income.

☐ Financial support of family members outside of the household (e.g. alimony, child support) that exceeds 10% of total gross annual household income.

☐ Temporary loss or reduction of income due to diagnosis or treatment.

☐ Permanent loss or reduction of income due to diagnosis or treatment.

☐ Receiving Charity Care from the ordering facility (attach documentation on facility letterhead with details).

☐ Other (please write in below or attach additional detail)

*Acknowledgment

I attest that I do not have sufficient resources or assets to enable me to pay for Foundation Medicine testing and also meet my existing financial obligations and liabilities. I understand that Foundation Medicine may reach out to me to verify the information that I have provided in this application for financial assistance. I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be a denial of financial assistance and I will be responsible for paying for the services provided.

*Patient OR Representative Name† (Print)

*Signature

*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, the patient has consented to my completing the application on his/her behalf, and the patient has provided the information used to complete this application and attests to its accuracy, as described in the above Acknowledgement. My signature is not an acceptance of financial responsibility or liability for the services rendered. If an Ordering Physician, my signature also indicates that, at the time of the application, the patient named above was unable to sign this form and no authorized Representative was available or willing to sign on the patient's behalf.

Return Signed Form to Attn: Access Team

Fax: 617.830.0279 Mail: 400 Summer Street, Boston, MA 02210 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.