Ambry Genetics®

Patient Assistance Program Application

Thank you for your interest in Ambry Genetics Corporation Financial Assistance Program. Please complete the information below and return the completed application along with your listed statement(s). We will process your request and notify you of your eligibility. Please allow up to 3 weeks for processing.

Note: An incomplete request will delay processing.

PATIENT INFORMATION

NAME: _____ TELEPHONE NUMBER: _____

DATE OF BIRTH: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

ACCESSION OR STATEMENT NUMBER(S) IF KNOWN:

TEST(S) ORDERED:

1. Do you have medical insurance coverage? Yes ☐ No ☐
2. If "Yes," please list responsible party information and include a copy of your insurance card.
   Insurance Carrier Name: _____
   Insurance Carrier Address: _____
   Insurance Carrier Phone Number: _____
   Policyholder Name: _____ ID#:_____
3. Total annual gross household income: $_____
   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
4. Number of family members in household supported by above income:_____

If you would prefer to fill this form out online, please scan the following QR code or visit ambrygen.com/PAP.

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I hereby acknowledge the above information is true and correct. I authorize Ambry Genetics 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 Genetics 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 Genetics Corporation 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/RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PRINT NAME _____

Ways to Submit

Email:
billing@ambrygen.com
Subject: Patient Assistance Application

Fax:
949-900-5501

Mail:
1 Enterprise
Aliso Viejo, CA 92656
Attn: Billing

FOR INTERNAL USE ONLY:

Customer Service Phone Representative Name: _____

Date: _____

INVOICE NUMBER	DOS	OWED AMOUNT	% APPROVED	ADJUSTED AMOUNT	DENIAL REASON	PATIENT CONTACT DATE

Processor Name: _____

Date Received: _____

Date Processed: _____

See https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

One Enterprise, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

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