

## 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 \_\_\_\_ 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 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

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

4. Number of family members in household supported by above income:





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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 S	IGNATURE _				DATE	
PRINT NAME						
Ways to Submit						
Email: billing@ambrygen.com Subject: Patient Assistance Application				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:						

One Enterprise, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**@2025 Ambry Genetics Corporation. All rights reserved. Ambry Genetics\* is a registered trademark of Ambry Genetics Corporation.

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

Date Processed: \_