

# VERISTRAT® PATIENT ASSISTANCE PROGRAM APPLICATION



## ENROLLMENT INSTRUCTIONS

Biodesix' Patient Assistance Program (PAP) offers assistance to patients without insurance. Through this program, many patients are able to have the VeriStrat test performed at no cost as part of their health care management. When a physician decides to order the VeriStrat test and recognizes that the patient is uninsured and may require uninsured patient assistance, the physician may submit the Patient Assistance Program Application along with the VeriStrat Test Request Form. The application may also be faxed separately to the VeriStrat Support at 1-866-465-1729. Biodesix will review the application and determine if the VeriStrat test will be provided to the patient at no charge.

## STEPS TO APPLY FOR THE PATIENT ASSISTANCE PROGRAM:

### 1. PATIENT MUST MEET THE CRITERIA BELOW:

- a. The patient must be uninsured and have no medical coverage.
- b. The patient must not be eligible for coverage through any local, state or federal programs.
- c. The physician or facility must be providing no-cost or reduced-cost treatment for the patient.
- d. The patient must have had the VeriStrat test performed.

### 2. COMPLETE FORM

The physician must mail or fax the completed PAP application form to Biodesix. The PAP application may be submitted to Biodesix either before or after testing. The application may be sent along with the Test Request Form in the VeriStrat Sample Collection Kit. The application may also be mailed or faxed separately to Biodesix' VeriStrat Support as indicated below.

## APPLICATION REVIEW

Once the application has been received, Biodesix will review to ensure the form is complete. If complete, an approval letter will be sent to the physician and the patient confirming that the VeriStrat test will be provided at no cost to the patient.

If you have any questions regarding the PAP, please contact the **VeriStrat Support Hotline at 866-432-5930**, Option 2.

*Please complete the application on the next page and submit to Biodesix.*

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## PATIENT INFORMATION - Please complete all sections

Patient Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PHYSICIAN INFORMATION

Physician Name \_\_\_\_\_ State License Number \_\_\_\_\_

Facility Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

## PHYSICIAN SIGNATURE

*I certify the above patient is uninsured and does not have any financial means to provide payment for the test requested.*

*I further certify that I/my facility is providing no cost or reduced cost treatment to this patient.*

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_



Broomfield, CO 80021

Please return completed application to:  
Biodesix Financial Assistance Program

File 31129  
PO Box 60000  
San Francisco, CA 94160  
Or fax to: 1-866-465-1729



**VeriStrat®**  
Support Hotline  
1-866-432-5930