biodesix

VERISTRAT® FINANCIAL ASSISTANCE PROGRAM APPLICATION

PROGRAM OVERVIEW

Biodesix is committed to making VeriStrat accessible to patients who need the test. As such Biodesix has established the Financial Assistance Program (FAP) to help reduce or eliminate cost a patient might owe. Qualification for the program is based on the patients individual financial need.

To apply for the financial assistance program the patient must submit a completed application. Once the application is received, Biodesix will review the application and determine eligibility.

STEPS TO APPLY FOR THE FINANCIAL ASSISTANCE PROGRAM:

PATIENTS MUST MEET THE CRITERIA BELOW TO QUALIFY FOR THE FAP:

If patient is uninsured and has no medical coverage the following criteria apply:

1. The patient must not be eligible for medical coverage through any local, state or federal programs.
2. The physician or facility must be providing no-cost or reduced-cost treatment for the patient.

If the patient has private insurance the following criteria apply:

1. The patient's annual adjusted gross income must not exceed $150,000.
2. The patient must be able to provide acceptable proof-of-income documentation.
3. The patient's net worth cannot exceed $2,000,000.

COMPLETE FORM

The patient or physician must mail or fax the completed application form to Biodesix either before or after testing. The application may also be sent along with the Test Request Form in the VeriStrat Sample Collection Kit.

APPLICATION REVIEW

Once the application has been received, Biodesix will review to ensure the form is complete and determine patient eligibility. Once eligibility is determined appropriate action will be taken.

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

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

biodesix

VERISTRAT® FINANCIAL ASSISTANCE PROGRAM APPLICATION

PATIENT INFORMATION

Please fill out the following section.

Patient Name ______________________ Phone ____________

Address ______________________

City ______________ State ____________ Zip ____________

If patient does not have medical coverage fill out section 1.
If patient has private medical coverage proceed to fill out section 2.

SECTION 1

Physician Name ______________________ State License Number ____________

Facility Name ______________________

Address ______________________

City ______________ State ____________ Zip ____________

Phone ______________ Fax ______________

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: ____________

SECTION 2

Annual adjusted gross income $ ______________ Number of Dependents ____________

- [ ] I have included the first two pages of my most recent tax return. (Form 1040).
- [ ] My net worth is not greater than $2,000,000.

If you wish to provide additional information about your financial situation for review please attach it to this application.

I certify that the information is complete and accurate to the best of my knowledge. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I hereby authorize the Biodesix Financial Assistance Program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature ______________________ Date: ____________

biodesix

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
P 1-866-432-5930
F 1-866-465-1729

©2010 Biodesix. All rights reserved. 152010 02/10