VERISTRAT® FINANCIAL ASSISTANCE PROGRAM APPLICATION

ENROLLMENT INSTRUCTIONS

Biodesix' Financial Assistance Program (FAP) offers assistance to patients with insurance, but for whom coverage for the VeriStrat test is denied or only partially provided, and the balance presents a financial burden. Through this program, many patients are able to receive financial assistance if the patient meets eligibility requirements. The FAP application form will be provided to all patients whose test is not fully covered by insurance. To apply for the FAP, the patient must submit a completed application along with the proof-of-income documentation. Once received, Biodesix will review the application and determine if the patient qualifies for assistance based on their income and individual circumstances. Please note that a Biodesix representative will be appointed to each patient who seeks FAP assistance. This representative will offer assistance with various tasks, such as completing and submitting the application, appealing a denied application and establishing a payment plan.

STEPS TO APPLY FOR THE FINANCIAL ASSISTANCE PROGRAM:

1. PATIENT MUST MEET THE CRITERIA BELOW:

a. The patient's annual adjusted gross income must not exceed $150,000.
b. The patient must be able to provide acceptable proof-of-income documentation.
c. The patient's net worth cannot exceed $2,000,000.
d. The patient must have third party coverage for medical services, either through governmental sources or commercial insurance.

2. COMPLETE FORM

The patient must mail or fax the completed application form, along with the appropriate proof of income, to the address or fax indicated on the back side of the application. The FAP application may be completed before or after testing to determine if you may qualify to have the patient balance reduced. Biodesix will review the correspondence sent from your insurance to confirm any patient responsibility for the test.

3. PROOF OF INCOME

Acceptable proof-of-income document includes the first two pages of most recent tax return (Form 1040).

4. EXPLANATION OF CIRCUMSTANCES

In addition to the eligibility criteria listed above, Biodesix will consider a patient's extenuating circumstances in the FAP review process. On the application form, the patient has the option to provide an explanation of financial burdens that may hinder their ability to pay any remaining balance.

APPLICATION REVIEW

Once the completed application has been received, Biodesix will determine if the patient is eligible.

- If the patient is eligible, an approval letter will be sent to the patient and the patient's balance for the test will be reduced.
- If the patient's eligibility is denied, the patient will receive a letter explaining the reason for denial and outlining payment options.

If you have any questions regarding the 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.

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PATIENT INFORMATION - *Please complete all sections*

Patient Name ______________________ Phone ______________

Address ______________________

City ______________ State ______________ Zip ______________

Annual adjusted gross income $ ______________ Number of Dependents ______________

If you would like to provide an explanation as to why your financial situation may make sharing the cost of the VeriStrat test a burden, please do so in the space provided below.

☐ I have chosen not to provide additional information regarding my financial situation.

CHECKLIST FOR APPLICATION SUBMISSION

☐ I have filled out all fields on the application.

☐ 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.

☐ I have provided or declined to provide, additional financial information for review.

PATIENT SIGNATURE

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: ______________

Broomfield, CO 80021

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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