

Patient Financial Assistance Application

Financial Assistance is available to domestic residents of the US.

Please fax to: +1 (617) 418-2290 Email: client.services@foundationmedicine.com

*Required Information

For more information or to file your application online, visit: access.foundationmedicine.com

Patient Information		*Ordering Physician and Facility Information
*Last Name _____		Office/Practice/Facility Name _____
*First Name _____	MI _____	Ordering Physician _____
*DOB (MM/DD/YYYY) _____	*Sex <input type="checkbox"/> F <input type="checkbox"/> M	Phone _____
*Street Address _____	Apt. # *City _____	Fax _____
*State _____	*Postal Code _____	*Country _____
*Phone _____	<input type="checkbox"/> I authorize Foundation Medicine to leave a detailed voicemail at this phone number	Email _____
Email _____		

*Total Gross Annual Household Income	Extenuating Circumstances
Estimated Gross Annual Household Income (Current income. Estimated ranges not accepted.) _____	Please advise of any extenuating circumstance that you would like us to consider.
<input type="checkbox"/> Number of family members in household supported by above gross annual household income (including patient) Must be filled out to process form	<input type="checkbox"/> Retired (i.e., fixed income)
	<input type="checkbox"/> Short or long-term disability
	<input type="checkbox"/> Significant credit card debt
	<input type="checkbox"/> Significant medical expenses
	<input type="checkbox"/> Supporting family member(s) outside of household
	<input type="checkbox"/> Alimony and/or child support
	<input type="checkbox"/> Loss of income due to diagnosis or treatment (if both please explain) <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent _____
	<input type="checkbox"/> Unforeseen expenses (e.g., home or car repair, etc.)
	<input type="checkbox"/> Non-local travel expenses for treatment (e.g., hotel, airfare, etc.)
	<input type="checkbox"/> College expenses for child/children
	<input type="checkbox"/> Other (Please attach additional detail) _____
	<input type="checkbox"/> None

*Who Should We Contact with the Approval Decision?	
Ensure contact information for patient and facility is filled in at the top of the form.	
Check all that apply:	Preferred method of contact: (select one)
<input type="checkbox"/> Patient	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Mail
<input type="checkbox"/> Practice	<input type="checkbox"/> Email <input type="checkbox"/> Fax

*I Hereby Acknowledge the Above Information is True and Correct:	
Patient Name OR Personal Representative (Print) _____	Signature (Required) _____
Relationship to Patient _____	Date _____

As a Personal Representative of the patient, or an Ordering Physician completing this application on my patient's behalf, my signature also certifies that I have explained to the patient the nature and purpose of this application and that the patient has consented to my completing the application on his/her behalf.

Return Signed Form to Attn: Client Services	
Fax: 617.418.2290	Email: client.services@foundationmedicine.com

For patients with health insurance, the insurance provider will be billed first. Your qualified amount for financial assistance will be applied to any unpaid balance remaining after billing insurance.