APPLICATION FOR ECONOMIC HARDSHIP PROGRAM

Please fax or email completed form with the test requisition for review and approval:
Fax: 617-582-5842 | Email: reimbursement@claritasgenomics.com

PATIENT INFORMATION

Last Name ________________________ First Name ________________________ MI___ Birth date (MM/DD/YY) ____________

Home phone number __________________________________ Social Security number ____________________________

Address ______________________________ City___________________________ State_______ Zip Code______________

STATEMENT OF MEDICAL NECESSITY

______ (Provider Initials) I have determined that the ordered test(s) written below is/are medically indicated for the above-named patient.

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CERTIFICATION OF ECONOMIC HARDSHIP

The above patient has no medical insurance and I have established to my satisfaction that this patient's existing financial resources are not sufficient to cover medical expenses. I am providing comparable waived fee arrangements and I am requesting that s/he be included in the Claritas Genomics Economic Hardship Program. To the best of my knowledge, this patient is uninsured and has a household income below 100% of the Poverty Level as established by the U.S. Department of Health and Human Services.

Physician Signature ____________________________________ Medical License No.____________________________

Print Physician Name ____

Institution/Clinic ____

ADDITIONAL INFORMATION

This completed form must be received prior to submission of the sample for review and approval. Direct any questions about this program and/or validation of economic hardship to:

Claritas Genomics at 855-373-9003 or email: reimbursement@claritasgenomics.com.

Note: This form does not replace the official test requisition form, which must accompany the sample in order for testing to be initiated.

Accepted for Claritas Genomics by:

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Name Signature Date

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