Biocept
Completing the Answer™

Patient Financial Assistance Program Application

Billing Department 888-332-7410 • **FAX** 877-754-5606

Your treating physician requested that Biocept perform certain laboratory tests as part of your care and/or treatment. We understand that paying for medical care can be difficult and may present an undue hardship to some patients. As part of our ongoing commitment to patient care, Biocept strives to work with patients in a way that is fair and sensitive to your individual circumstances to help you to address the financial responsibilities for Biocept laboratory testing.

The Biocept Patient Financial Assistance Program assists qualifying patients to afford our testing services. To qualify, a Patient must either (a) have experienced or currently be facing a financial hardship that prevents obtaining insurance coverage; or (b) have a household income that falls below 400% of the U.S. Department of Health and Human Services Poverty Level.

If you choose to apply, you must fully complete and return this Application (with the documentation indicated) to Biocept. Once you have applied, we request that you make no payments until you receive notification from us regarding the status of your application. If you have any questions, please contact the Biocept, Inc. **Billing Department at 888-332-7410.**

Please complete the attached Patient Financial Assistance Program Application and fax it to 877-754-5606 or mail to:

BIOCEPT, INC.
ATTN: BILLING DEPT. – File 1689
1801 W. Olympic Blvd.
Pasadena, CA 91199-1689

PATIENT INFORMATION

Last Name First Name MI	Do you have medical insurance coverage? ☐ Yes ☐ No
	If "Yes," please list responsible party information and include a copy of insurance card.
Address	
City State Zip Code	Insurance Carrier Name
DOB (mm/dd/yyyy)	Insurance Carrier Phone Number
Date of Biocept Testing (mm/dd/yyyy)	Insurance Carrier Address
Patient Phone # Best time to reach you ☐ AM ☐ PM	Policyholder Name / ID #

In order to be considered for the Biocept Patient Financial Assistance Program, you must provide all of the following information and the specified documentation.

FINANCIAL INFORMATION*

Current annual household gross income	$
Number of household members dependent on the income stated above (including the applicant)	
Number of dependents currently attending college	
Annual tuition costs for the dependents listed above (please provide documentation)	$
Monthly mortgage, rent or property tax payment (please provide documentation)	$
Monthly car payments (please provide documentation)	$
Annual medical expenses not including the current bill for Biocept testing	$

THE FOLLOWING DOCUMENTS MUST BE SUBMITTED

- ☐ This application form completed and SIGNED by you or the person responsible for your care
- ☐ A copy of your most recent tax return or the past 2 years W-2's for all wage earners in your household
- ☐ Documentation of mortgage/rent/property tax payments
- ☐ Documentation of monthly car payments (if applicable)
- ☐ Documentation of tuition expenses (if applicable)
- ☐ Documentation of medical expenses
- ☐ Copy of any information provided by your insurance company related to the reimbursement of Biocept testing

(Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

*If you are currently receiving treatment from an institutional health care provider such as a hospital or hospice or other care facility (other than your physician), and you are also enrolled in a patient hardship program or charity care program maintained by the that institutional provider, you may submit documentation of that enrollment in place of the Financial Information (we will accept a certification signed by an authorized representative of the institutional provider).

I HEREBY ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE BIOCEPT, INC. TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING WHETHER I QUALIFY FOR THE BIOCEPT PATIENT FINANCIAL ASSISTANCE PROGRAM, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, BIOCEPT, INC. WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

Responsible Party Name (Print) Responsible Party Signature Date (mm/dd/yyyy)

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