GeneSight® Financial Assistance Program Application

The GeneSight Financial Assistance Program is available to help further reduce your cost for the GeneSight test(s) to $0, $100, or $200. Qualification is based on your household income, number of people in household, and other federal guidelines.

Visit GeneSight.com/cost to use our Financial Assistance Calculator to determine if you qualify.

1 Patient Information

Patient Name		
Address		
City	State	Zip Code
Phone	U.S. citizen or legal resident? ☐ Yes ☐ No	
Date of Birth		
Parent or Guardian Name (If applicable)		
What is your annual household income?		
How many people are in your household?		

PATIENT DECLARATIONS – PLEASE READ

I certify that I am not eligible for a state or federally funded healthcare program (such as Medicaid, Medicare, Medicare Advantage or TRICARE®). **I understand that all information provided to Myriad Neuroscience is subject to verification.** I hereby authorize Myriad Neuroscience to obtain and disclose information from healthcare providers, and other information as necessary to verify the information provided in this application.

I am aware that all of the information I am providing as part of this application will be used by Myriad Neuroscience to determine whether I qualify for the GeneSight Financial Assistance Program. By signing below, I verify that the information in this application, including documentation provided to verify household income, is complete, true and accurate. I understand that if any of the information I have provided proves to be incomplete, untrue or inaccurate, Myriad Neuroscience may reevaluate my financial status and take action as necessary and appropriate to collect any discount granted to me by Myriad Neuroscience. I also understand that if I do not qualify for this program, I will be notified by Myriad Neuroscience. I also understand that Myriad Neuroscience reserves the right at any time, and without notice, to modify the application form, modify or discontinue its Program and its eligibility criteria, or terminate assistance.

2 Signature of patient or legal guardian ______________________________ Date ______________

3 Include a copy of the first page of your 1040 tax form. You can black out your social security number.
Your application cannot be processed without the 1040 form.

4 **Send this application and the 1040 tax form via one of the following methods:**

Email	Fax	Mail
FAP@myriad.com	513.785.0881	Myriad Neuroscience PO Box 645685 Cincinnati, OH 45264-5685

CONFIDENTIAL HEALTHCARE INFORMATION
Billing 888.496.2391 • Fax 513.785.0881

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