

Athena Diagnostics Financial Assistance Program Application

Four Biotech Park • 377 Plantation Street • Worcester, MA 01605 • (800) 394-4493

Please Read: Before submitting this form, please be sure that both the physician and patient sections are completed. Athena will not consider incomplete applications. All information provided in this application will be used only for the purpose of determining whether you qualify for Athena's Financial Assistance Program. Athena agrees not to disclose any individually identifiable information provided in this application to any third party, except as provided herein or as required by law. Please send this form, along with the documentation requested below, to Athena Diagnostics, Four Biotech Park, 377 Plantation Street, Worcester, Massachusetts 01605. If you have any questions regarding this form, please call (800) 394-4493 and ask for a Reimbursement Services Representative.

Physician Information

Name/Professional Designation: _____ UPIN# _____

Address (no P.O. Box) _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Ext. _____ Fax: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ Date of Birth: _____

Address (no P.O. Box) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Office Phone: _____ Fax: _____

Financial Information

Sources of Income: _____ # in Household _____ # of Dependents _____

Current Monthly Household Income (must include all in household): _____

Annual Family Adjusted Gross Income Last Calendar Year _____

Attach documentation of current and annual income (e.g., most recent tax form or W-2).

Total Medical Bills in Past 12 Months: _____ Attach documentation (you may delete medical information, such as diagnoses and prescribed treatments).

Test Information

Unit Code(s) _____ Test Name(s) _____

3rd Party List Price _____ **Qualified Applicant Cost*** _____

**** You must submit this amount with your application.*** If you qualify for assistance, Athena will not process your payment until testing is complete. If you do not qualify for assistance, Athena will contact you and request that you forward payment for the balance of the cost of testing before testing is performed. If you elect not to proceed, Athena will return your payment to you.

Insurance Information

Please indicate whether the patient has any form of third party healthcare coverage (partial or full) for the test(s) requested, including:

Medicare Yes No

Private Insurance/HMO Yes No

Medicaid Yes No

Other State/Governmental Program Yes No

Provide details related to any "yes" answer on the following page. If you have Medicaid coverage, please attach a copy of your eligibility card.

Additional Information or Remarks:

PATIENT DECLARATIONS

Please read: I am aware that all of the information I am providing as part of this application will be used by Athena to determine whether I qualify for its Financial Assistance Program. By signing below, I verify that the information on this application, including the documentation provided to verify household income and medical expenses, is complete, true, and accurate and that I have not received any other financial assistance for the payment of the test(s) ordered. I understand that, if any of the information I have provided proves to be untrue, Athena may re-evaluate my financial status and take action necessary to collect any discount granted to me by Athena. I also understand that if I do not qualify for this program, I will be notified by Athena.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If Applicable:

Responsible Party Name (Print): _____

Responsible Party Address and Daytime Phone: _____

Responsible Party Signature: _____ Date: _____

Payment Information (select one):

I have attached a personal check Qualified Applicant Cost* _____

I choose to pay by credit card

Credit Card Number _____ Exp Date _____

Security Code # _____ Name as it appears on credit card: _____

Accession Number _____

I authorize Athena Diagnostics, Inc. to bill my credit card for the charges associated with this testing.

Cardholder Signature _____ Date _____