



PROMARK® PATIENT ASSISTANCE PROGRAM FORM

We're committed to helping you manage your out-of-pocket costs for ProMark.

To determine if you might qualify for financial assistance, please complete the information below so we can review your eligibility status for the ProMark Patient Assistance Program.

We will contact you for pre-test authorization only if we receive your completed form at the time of service, and if your out-of-pocket responsibility may be more than \$350. If we do not receive your completed form at the time of service, don't worry, you can still apply for the Patient Assistance Program at a later date.

Last name: _____ First name: _____ Date of birth: _____

Street address: _____ City: _____ ZIP: _____

Primary phone: _____ Secondary phone (optional): _____

Email address (optional): _____

I have verified that the insurance information provided by my physician is up-to-date.

I am: *(please check all that apply)*

A United States citizen or legal resident

At least 21 years of age

Not covered by any federal or state funded insurance plan (e.g., Medicare, Medicaid, Tricare)

Ordering physician name: _____ Date of ProMark test: _____

Total annual gross household income: _____ Number of people in household: _____

By signing this form, I certify that the information is complete and accurate to my best knowledge. I understand that, (1) I may not be eligible for the ProMark Patient Assistance Program if my insurance policy covers ProMark and requires me to pay a specific amount; (2) I may be asked to provide documentation of income at a later date; and (3) all medical and financial information will be kept confidential, except as otherwise required by law. Metamark reserves the right to make any changes or amendments to the ProMark Patient Assistance Program (including but not limited to suspending, discontinuing, or terminating the program), at any time and in Metamark's sole discretion, without notice.

I authorize the release to Metamark of any medical and insurance information necessary to process claims for services provided by Metamark. I assign my right to and authorize payment of medical benefits to Metamark for all services provided by Metamark. I authorize Metamark to pursue on my behalf all necessary appeals with my health insurance company in relation to services provided by Metamark. If my health insurance company sends payment to me, I shall pay Metamark the full amount of such payment. I understand that I may not qualify for the ProMark Patient Assistance Program and may have an additional out of pocket responsibility.

Patient signature: _____ **Date:** _____

Physician: Please return the completed and signed form to Metamark with specimen alongside requisition.

Or:

Fax to: 1-706-364-4371

Mail to: Metamark, Inc., 985 Broad Street, Suite A, Augusta, GA 30901

Email to: ProMarkBilling@Metamarkgenetics.com

Questions about ProMark billing or the ProMark Patient Assistance Program? Please call us at +1-877-743-3338.