Financial Assistance Program Application

We understand the clinical genetic testing can be expensive, so we offer a Financial Assistance Program (FAP). To help us determine whether you qualify for the FAP, please return the application and necessary paperwork to us.
IMPORTANT: All information you send to us is handled safely and securely. Only your **full name, date of birth, and gross income information** are needed on the documents you send us. Please block out other sensitive personal information, such as social security number and net income.

Do not send originals. Please send copies of the following documents, which will be scanned and shredded.

- **Completed Application and any of the following supporting documentations:**

- A copy of your most recent Federal Income Tax Return (1040 or 1040EZ), along with W-2 forms
- Copies of pay stubs from the last 30 days for each household member.
- If you and/or your spouse are unemployed and receiving unemployment compensation, supply verification of unemployment benefits.
- If you do not have a source of income, provide a written statement on Page 2 explaining how monthly expenses are being met.
- If you are unable to provide any of the documents described above, use the comment section on page 2 to explain why they are not included.

Please return the signed application and supporting documents to:

billing@rprdx.com

OR

RPRD Diagnostics, LLC
c/o Patient Financial Services
1225 Discovery Parkway, Suite 260
Milwaukee, WI 53226

RPRD reserves the right to request additional information before approving the patient's request for assistance under the FAP.

RPRD DIAGNOSTICS
— Right Patient | Right Drug —

Patient Information

Name _____ Date of Birth _____

Phone Number: _____ Email address:_____

Address:

_____

Household size: _____ Household Annual Income (pre-tax)$ _____

Additional Comments / Explanation of Circumstances:

I certify that the above information is complete and accurate. I hereby authorize RPRD Diagnostics, LLC and its contracted billing company to release any information necessary for verification of statements made on this application. Furthermore, I hereby authorize release of any information necessary to RPRD Diagnostics, LLC for the purpose of verification of statements on this application. This consent shall expire six (6) months from the date hereof. This consent is provided pursuant to Wis. Stat. § 146.81.

Signed _____**Date**_____

RPRD Diagnostics, LLC reserves the right to deny any application if it is determined the information has been falsified, is incomplete, or for failure to apply or comply with other applicable assistance programs. All patient's financial responsibility will then become due. If you receive a payment from a third party related to the medical charges, you agree to immediately remit those funds to RPRD Diagnostics, LLC.

For assistance or questions, please call RPRD at (414) 316-3097.