FOUNDATION MEDICINE®

FoundationACCESS: Patient Financial Assistance Application

PATIENT INFORMATION

Last Name	First Name	MI
Street Address		Apt. #
City	State	Zip
Foundation Medicine Account Number		
Phone Number	Email address	

ORDERING PHYSICIAN AND FACILITY INFORMATION

Office/Practice/Institution Name
Ordering Physician
Phone Number
Fax Number
Email address

TOTAL ANNUAL GROSS HOUSEHOLD INCOME:

☐	Less than $20,000	☐	$65,000 - $75,000
☐	$20,000 - $30,000	☐	$75,000 - $90,000
☐	$30,000 - $40,000	☐	$90,000 - $105,000
☐	$40,000 - $50,000	☐	$105,000 - $120,000
☐	$50,000 - $60,000	☐	Greater than $120,000
Number of family members in household supported by above income:		#of persons:	

PLEASE ADVISE OF ANY EXTENUATING CIRCUMSTANCES THAT YOU WOULD LIKE US TO CONSIDER:

Who should we contact with the approval decision? Check all that apply: ☐ Patient ☐ Practice

Preferred method of contact: ☐ Phone ☐ Email ☐ Mail ☐ Fax

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT:

Patient Name OR Personal Representative (Print) _____ Signature _____

Relationship to Patient _____ Date _____

Please, return signed form to Attn:

Client Services

Fax: 617-418-2290

% of Assistance:
Approved By:
Date:

We will automatically respond to the person who originally submitted the form within 1-2 business days. If you want us to contact anyone else, please, indicate:

Person to contact:
Phone number:
Best time to call:

For patients with health insurance, the insurance provider will be billed first. Your qualified amount for financial assistance will be applied to any unpaid balance left after billing Insurance.