BostonGene

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FINANCIAL ASSISTANCE PROGRAM APPLICATION FORM

BOSTONGENE OFFERS A FINANCIAL ASSISTANCE PROGRAM TO PROVIDE ALL PATIENTS AND OPPORTUNITY TO RECEIVE THE TEST NECESSARY FOR CLINICAL DECISION MAKING AND TO HELP PATIENTS IN NEED TO DECREASE THEIR OUT-OF-POCKET EXPENSES.

WE BELIEVE YOU SHOULD HAVE ACCESS TO MEDICALLY NECESSARY TESTS ORDERED BY YOUR PHYSICIAN.

PLEASE COMPLETE THIS FORM TO APPLY FOR THE BOSTONGENE FINANCIAL ASSISTANCE PROGRAM.

BOSTONGENE WILL CONSIDER THE FINANCIAL APPLICATION TAKING YOUR HOUSEHOLD INCOME AND OTHER LIFE CIRCUMSTANCES INTO ACCOUNT.

*REQUIRED FIELDS MUST BE FILLED OUT.

PATIENT INFORMATION:		
FIRST NAME*	LAST NAME*	
DATE OF BIRTH*	SEX ☐ M ☐ F	
PHONE	EMAIL	FAX
STREET ADDRESS	CITY	
STATE	COUNTRY	POSTAL CODE
PREFERRED METHOD OF CONTACT	☐ PHONE ☐ EMAIL ☐ FAX ☐ MAIL TO HOME ADDRESS	

PATIENT BACKGROUND:
PATIENT GROSS ANNUAL HOUSEHOLD INCOME (ESTIMATE)*
HOW MANY FAMILY MEMBERS ARE IN YOUR HOUSEHOLD?*
PLEASE INDICATE ANY SPECIAL CIRCUMSTANCES (E.G. MEDICAL OR CREDIT CARD DEBT/LOST JOB RECENTLY)

ORDERING PHYSICIAN INFORMATION:	
FIRST NAME	LAST NAME
INSTITUTION	
PHONE	EMAIL

PATIENT CONSENT TO APPLICATION:	
ARE YOU A PATIENT? ☐ YES ☐ NO	
IF NOT, PLEASE INDICATE YOUR NAME AND RELATIONSHIP TO THE PATIENT	
BY SIGNING THIS FORM, I CERTIFY THAT ALL THE INFORMATION PROVIDED IN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BOSTONGENE TO USE THE INFORMATION PROVIDED IN THIS APPLICATION TO DETERMINE MY ELIGIBILTY FOR THE BOSTONGENE FINANCIAL ASSISTANCE PROGRAM.	
SIGNATURE*	DATE*

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