OmniSeq CARES – Financial Support Application

Application for patients who are invoiced by OmniSeq, Inc.

700 Ellicott Street, Buffalo, NY 14203
Phone: (800) 781-1259

- **OmniSeq CARES representatives are available to answer any questions Monday through Friday 8:00 AM – 5:00 PM EST.**
- **For timely processing of your application, please complete all fields.**
- **Return completed to PO Box 8000, Dept 815, Buffalo, NY 14267-0002, by fax 888-770-4931 or secured email to CARES@omniseq.com.**

Section 1 - Patient Information

Last Name		First Name	MI
Date of Birth	Account # from statement (leave blank if unavilable)	Email	
Home Address			
City		State	Zip
Home Phone Number		Cell Phone Number	
Ordering Physician/Practice			

Section 2 - Responsible Party Information (if different from above)

(Patient consent must be given to discuss account with a 3rd party – See Section D)

Last Name	First Name	MI
Billing Address		Relationship
City	State	Zip
Home Phone Number	Cell Phone Number	Email

Section 3 - Financial Information (enter in applicable box(es))

Total Earned Annual Gross Household Income (income before taxes and deductions)	
Unemployment Income	
Social Security Income	
Additional Income (please specify)	
Number of persons in household supported by above income	
Are you currently employed?	☐ Yes ☐ No
Optional: List other health care expenses, amounts and indicate how often the cost occurs.	

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Section 4 – Supporting documentation

Please attach at least one of the following required documents:

☐ Last 2 paystubs for each member of household
☐ Copy of last year's income tax return
☐ Copy of last year's W2 form
☐ Copy financial assistance approval from a hospital, dated within the last year
☐ Copy of social security or social services award letter

Section 5 – Consent (Optional)

I authorize OmniSeq,Inc. to discuss my patient account information with the following party(ies). Patient account information may include, but is not limited to, codes/procedures billed, insurance carrier information, account balance and results of financial application. Test results will not be discussed with a third party.

Last Name	First Name	MI
Relationship	Phone Number	Email address

Last Name	First Name	MI
Relationship	Phone Number	Email address

Section 6 – Signature

All information in this application is true to the best of my knowledge. I authorize use of this information to determine my eligablity for OmniSeq, Inc. Financial Assistance. I agree to provide additional documentation upon request. I understand that this confidential information cannot be disclosed to any party outside of OmniSeq, Inc. without my prior approval.

_____

Patient Name

_____ _____

Patient Signature Date

Return completed to PO Box 8000, Dept 815, Buffalo, NY 14267-0002, by fax 888-770-4931 or secured email to CARES@omniseq.com.

For office use only:

Reviewed by:		% of assistance:	
Reviewed on:		Patient contacted on:	
Approved by:		Patient contacted by:	
Approved on:		Approved by Finance on:	
Notes:			