APOLLO GENETICS
1111 DRAPER PARKWAY, STE 200
DRAPER, UTAH 84020

TELEPHONE
(855) 322-5120
EMAIL
memberservices@apollogenetics.com

PATIENT ASSISTANCE PROGRAM & APPLICATION

After careful review, your healthcare provider determined that genetic testing by Apollo Genetics Laboratories is necessary. Apollo Genetics abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Apollo Genetics recognizes that circumstances may arise where an individual is unable to pay. We adopted a process of screening requests for delayed payment plans, discounts, or forgiveness of debt based on individual circumstances. This patient assistance program is our commitment to work with patients and assure that necessary genetic testing can be provided at a reasonable cost for those with a financial need or for those who are under insured. Apollo Genetics will calculate your financial need based on your annual adjusted gross income and the number of family members in your household.

Program Requirements

Patient has healthcare insurance, but needs financial assistance.

Family Size (Excluding current pregnancy)	Combined Family Income Equal to or Less Than*
1	$49,960
2	$67,640
3	$85,320
4	$103,000
5	$120,000
6	$138,360
7	$156,040
8+	$173,720

Patient Information

Patient Last Name _____ MI _____

Patient First Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Email _____

Primary Insurance Company Name _____

Total Annual Gross Household Income _____ Number in household _____

Test Code Ordered _____

* Patient assistance is based on the 2022 Federal Poverty Income Sliding Scale. Combined household income must be less than or equal to four times the federal poverty guidelines. This is based on the HHS Poverty Guidelines. Restrictions may apply.

Attestation

I hereby certify that the information provided by myself, or my legal representative is true and accurate. I have read and understand the Apollo Genetics Patient Assistance Program requirements. I understand and agree that Apollo Genetics reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to verify the information I provide on this application. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, government program or other source of financial assistance. I understand that if I do not qualify, I will be notified. I acknowledge that I am neither related to, nor employed by, the healthcare provider ordering the genetic tests. Apollo Genetics can require the patient to pay full price if it later determines that inaccurate information was provided.

_____ _____

Signature of Patient or Legal Representative **Date**

OFFICE USE ONLY

_____ APPROVED _____ DENIED _____ _____/_____/_____

Initial Date