CARE Patient Assistance Program Application

CORUS CAD

EFFECTIVE: JULY 2016

At CardioDx®, we are committed to providing all appropriate patients with access to the Corus CAD test, regardless of their insurance coverage or ability to pay for the test. The Corus Access and Reimbursement (CARE) Patient Assistance Program was developed to assist uninsured patients and patients whose insurance does not yet cover Corus CAD with their out of pocket costs.

Eligibility Requirements

To qualify for the CARE Patient Assistance Program, you must meet the annual household gross income eligibility requirements as shown below and submit a completed application.

To determine if you meet the income level requirements, use the scale below to identify the number of people in your household and the maximum annual household gross income in the matching column. If your annual household gross income is less than or equal to the amount listed, you may qualify for the CARE Patient Assistance Program. Income amounts provided on this form will be verified to ensure eligibility for the program. The information will be verified externally which will have no impact on a consumer's credit score.

Patients who do not qualify for the program include those patients

- Who participate in government funded insurance plans such as Medicare and Medicaid
- With insurance who choose to pay for Corus CAD out-of-pocket
- Whose insurance company covers Corus CAD and does not allow CardioDx to waive patient financial responsibility (such as Aetna)

To apply for the program, please complete the section below and return the completed application to CardioDx.

Patient Application

ALL BOLD FIELDS MUST BE COMPLETED ON FORM. OTHER INFORMATION MAY BE PROVIDED ON A SEPARATE ATTACHMENT. Please provide a copy of your insurance card or check here if you are uninsured. ☐

Last Name: _____ **First Name:** _____ Date of Birth: (mm/dd/yyyy) / /

Street Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Name of Ordering Clinician: _____ **What is Your Total Annual Gross Household Income?** $ _____ Date of Corus CAD Testing: (mm/dd/yyyy) / /

How many people are in your household that you claim on your tax form? _____

Patient Signature: _____ **Date:** _____

By signing this form, I certify that the information is complete and accurate to the best of my knowledge. I understand that: 1) I may not be eligible for the CARE Patient Assistance Program if my insurance policy covers Corus CAD and requires me to pay a specific amount, 2) I may be asked to provide documentation of income at a later date, 3) all medical and financial information will be kept confidential, except as otherwise required by law, 4) I may be asked to assist CardioDx appeal my insurance company if my claim is denied, and 5) that the income information provided on this application will be verified externally which will have no impact on a consumer's credit score.

I authorize the release to CardioDx of any medical and insurance information necessary to process claims for services provided by CardioDx, Inc. I assign my right to and authorize payment of medical benefits to CardioDx, Inc. for all services provided by CardioDx, Inc. I authorize CardioDx, Inc., to pursue on my behalf all necessary appeals with my health insurance company in relation to services provided by CardioDx, Inc. If my health insurance company sends payment to me, I shall pay CardioDx, Inc. the full amount of such payment.

Please return the completed and signed form to CardioDx by mail or fax to:

Return by Mail: CardioDx, Inc.
Dept CH 19929
Palatine, IL 60055-9929

Return by Fax: 1.866.941.4998

If this application is returned with the Test Requisition Form (TRF), write the TRF number below or apply the peel off label from the accompanying sheet.

TRF_____ _____ _____ _____ _____ _____ _____

Number of people in your household	1	2	3	4	5	6	7	8
Maximum annual household gross income to qualify for $0 patient cost for the test	$23,760.00	$32,040.00	$40,320.00	$48,600.00	$56,880.00	$65,160.00	$73,460.00	$81,780.00

CardioDx is committed to protecting the privacy of your health information. Your information will be used and disclosed only for treatment, payment, healthcare operations, and other purposes permitted or required by law.

CardioDx reserves the right to change the program or program criteria at any time and without notice.

Customer Service **Email:** service@cardiodx.com P 866.941.4996

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