RiskReveal™

Financial Assistance Application

Patient Information

Patient Name _____

Street Address _____

City _____ State _____

Postal Code _____ Country _____

Phone _____ Date of Birth (mm/dd/yyyy) _____

Date of Service (mm/dd/yyyy) _____ Accession number _____

Do you receive any government benefits, such as Medicare and/or Medicaid? ◯ Yes ◯ No

Number of people in your household _____

Last year's taxable income $ _____
(Line 22 of IRS form 1040)

Razor Genomics, Inc.™ may request proof of income prior to approving your application for Financial Assistance. The Razor Genomics, Inc. Financial Assistance program is based on the current years Federal Poverty Guidelines published at: **https://www.hrsa.gov/get-health-care/affordable/hill-burton/poverty-guidelines.htm.**

Submittal Information

Please initial the following statements:

_____ I certify that the information contained in this application is complete and correct to the best of my knowledge.

_____ I certify that I will provide proof of income within 15 days should it be requested.

Patient Signature _____ Date Signed _____

Printed Patient Name _____

Please submit your completed and signed application form via fax or mail:

Mail: Razor Genomics, Inc
DEPT 2033
PO Box 122033
Dallas, TX 75312-2033

Phone/Fax: 1-844-662-6298
Fax: 1-800-406-5189

Razor Genomics, Inc. will send a notification letter indicating your eligibility determination. An incomplete form may result in delays to processing your application

Internal Use only:

Information Received Verbally by _____ Date Received _____

Qualified _____ % _____ Not Qualified _____ Date Sent to Billing _____

For any questions please contact the Razor Genomics, Inc. Customer Service Team at:
1-844-662-6298 or cs@razorgenomics.com

RAZORGENOMICS™
Transforming Cancer Care