



Transgenomic Financial Assistance Program Application

Financial assistance is available in the form of reduced costs for uninsured patients that meet our financial hardship guidelines. Submit this form making sure that both the physician and patient sections are complete. All information provided in this application will be used only for the purpose of determining eligibility for financial assistance. Transgenomic agrees not to disclose any individually identifiable information provided in this application to any third party except as required by law. Please send this form, along with documentation requested below, to Transgenomic, Inc., 12325 Emmet St., Omaha, NE 68164. If you have any questions regarding this form, please call (866) 500-4363.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
Social Security Number: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Office Phone: _____ Fax: _____

Financial Information

Current Monthly Household Income: _____
Annual Adjusted Gross Income: _____ **Submit most recent tax form or W2(s).**

Physician Information

Name and Professional Designation: _____ UPIN#: _____
Address: _____
City: _____ State: _____ Zip: _____
Office Phone: _____ Ext.: _____ Fax: _____

Test Information

Test Name(s) _____

Please read: I am aware that the information provided in this application will be used by Transgenomic to determine Financial Assistance Program eligibility. By signing below, I verify that the information on this application including supporting documentation is complete and accurate and that I have not received any other assistance for the test(s) ordered. I understand that, if any of the information is found to be untrue, Transgenomic may re-evaluate my financial status and take action necessary to collect any discount granted to me.

Patient Name (Print): _____
Patient Signature: _____ Date: _____

Responsible Party Name if Applicable (Print): _____
Responsible Party Address and Phone Number: _____

Responsible Party Signature: _____ Date: _____

