



## APPLICATION FOR COMPASS

### Patient Assistance Program for Interpace Diagnostics Testing Services

| PATIENT INFORMATION (please print) |        |         |   |                       |   |
|------------------------------------|--------|---------|---|-----------------------|---|
| Patient's Last Name:               | First: | Middle: | Title:<br><input type="checkbox"/> Mr. <input type="checkbox"/> Miss<br><input type="checkbox"/> Mrs. | Birth Date:<br>/ /    | Gender:<br><input type="checkbox"/> M<br><input type="checkbox"/> F |
| Street Address or P.O. Box:        |        |         | Home Phone:<br>(    )   | Cell Phone:<br>(    ) |   |
| Apt/Suite: (optional)              | City:  |         | State:  | ZIP Code:             |   |

| FINANCIAL INFORMATION   |               |
|---|---------------|
| Current annual household gross income   | \$            |
| Current insurance carrier   | Subscriber ID |
| Number of household members dependent on the above income (including applicant) |               |

Patient/Guardian Signature

Date of Signature

\_\_\_\_\_ / / \_\_\_\_\_

By signing above, I choose to apply to the COMPASS Program. If I am eligible for enrollment in COMPASS, I understand that my financial responsibility may be limited based on my eligibility. I attest that the information provided is complete and accurate. I understand that during my participation in the COMPASS Program, Interpace Biosciences may request information related to this application. All information will remain confidential and will not be shared with any other entities. I understand that Interpace Biosciences reserves the right to change or discontinue this program at any time.

Please mail this completed form to: Interpace Diagnostics Corp. PO Box 392719, Pittsburgh, PA 15250-2719

Conditions:

\*To be considered eligible for the COMPASS Program, insured patients agree to provide patient consent for Interpace Diagnostics to appeal denials with the insurer.

\*COMPASS is not available to patients covered by Medicare, Medicaid, or any other government funded program, or where the program is restricted or prohibited by carrier contract limitations, or federal or state law. COMPASS is only available to patients within the United States.

\*This application is valid for a period of 6 months from the date the application was filed.