Interpace Diagnostics®
Resolving Diagnostic Uncertainty

COMPASS

APPLICATION FOR COMPASS

Patient Assistance Program for Interpace Diagnostics Testing Services

PATIENT INFORMATION (please print)					
Patient's Last Name:	First:	Middle:	Title: ❒ Mr. ❒ Miss ❒ Mrs.	Birth Date: / /	Gender: ❒ M ❒ F
Street Address or P.O. Box:			Home Phone: ( )	Cell Phone: ( )	
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. 2515 Liberty Avenue, Pittsburgh, PA 15222

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.