Myriad Financial Assistance Program Application

The Myriad Financial Assistance Program ("Program") is available for only those patients who are both uninsured and also meet the financial and medical requirements described below. Both applicants and their healthcare providers must complete their applicable sections in order for the patient to be eligible for the Program. Note: An incomplete request will delay processing.

PATIENT Section:

Name (Last, First, Middle)	Social Security #	Date of Birth

☐ I certify that I do not carry health insurance of any kind, including State or Federal funded programs (i.e. Medicare, Medicaid).

☐ I certify that my gross annual household income is $ _____. Number of persons in the family household is _____. Supporting income documentation is required with this application to be eligible for this Program. Supporting documentation must be in the form of an IRS publication Form 1040. If an IRS publication **Form 1040** is not available, submit a brief letter explaining your income source and why an IRS publication **Form 1040** is not available.

☐ I certify that my gross annual household income is equivalent if not less than the financial guidelines set forth by Myriad Genetic Laboratories, Inc. This information is available on the following website: **www.myriadtests.com/provider/reimr.htm.**

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Myriad Financial Assistance Program requirements. I understand and agree that Myriad Genetic Laboratories, Inc. reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to audit the information I have provided on this application. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, government program or other source of financial assistance.

_____

Patient Signature **Date**

_____

Print Name

HEALTH CARE PROVIDER Section:

☐ I have enclosed an accurate and completed Myriad Test Request Form (TRF). The patient's specimen must accompany the TRF and this completed application.

☐ I have verified that this patient meets the medical criteria for the test(s) ordered on the TRF. The medical criteria and program details are available on the following website: **www.myriadtests.com/provider/reimr.htm.**

As the medical professional providing health care to this patient, I hereby certify that the information provided by myself is true and accurate.

_____

Health Care Provider Signature **Date**

_____

Print Name

Myriad Genetic Laboratories, Inc., 320 Wakara Way, Salt Lake City, UT, 84108
Phone: (800) 469-7423, Fax: (801) 584-3615

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