Oncology Patient Access Form

Please submit form with test order or fax to: (855) 718-4249
Attn: Labcorp Oncology Services
Email: RCMOncologyServices@labcorp.com

The submission of this form is not an order for a test. This form is for patient verification and financial assistance review for OmniSeq INSIGHT®, IntelliGEN® Myeloid, and Labcorp® Plasma Focus™ testing only. Labcorp may use information obtained on this form and other information provided by the patient and/or ordering provider or his/her designee to initiate insurance verification and assess financial need. This includes the right to seek supporting documentation for the below request. Any approved assistance will be applied after billing the patient's insurance. Assistance approval does not guarantee full payment.

***Required Information**

RESET FORM Clear All Fields

*TESTING INFORMATION (TO BE COMPLETED BY PROVIDER)

☐ **OmniSeq INSIGHT®** ☐ **IntelliGEN® Myeloid**

☐ **Labcorp® Plasma Focus™**

***ICD Code**

PATIENT INFORMATION

*Last Name | *First Name | MI

*DOB (MM/DD/YYYY) | *Sex ☐ F ☐ M

*Street Address | *Apt.# | *City

*State | *Zip Code | *Country

*Phone | *Email

*TOTAL GROSS ANNUAL HOUSEHOLD INCOME

Estimated Gross Annual Household Income

☐ **Number of family members in household supported by above gross annual household income**

Total household income includes the following for all members of your household: gross salary, unemployment compensation, disability and workers compensation, social security disability (SSDI) and/or supplemental security income (SSI), public assistance, (TANF, SNAP, etc.), other income.

*WHO SHOULD WE CONTACT WITH THE APPROVAL DECISION?

Ensure contact information for patient and facility is filled in at the top of the form.

Check all that apply:	**Preferred method of contact:**
☐ Patient	☐ Phone ☐ Email ☐ Mail
☐ Practice	☐ Phone ☐ Email ☐ Mail ☐ Fax

ORDERING PHYSICIAN AND FACILITY INFORMATION (TO BE COMPLETED BY PROVIDER)

*Office/Practice/Facility Name

*Account #

*Ordering Physician

*Phone | *Fax

*Email

PATIENT INSURANCE INFORMATION

*Does the patient referenced have medical insurance coverage? ☐ Yes ☐ No

If "Yes", please list responsible party information:

Face sheet and/or copy of insurance card – both sides ☐ See attached

*Insurance Carrier Name

*Insurance Carrier Phone

*Policyholder Name

*Policyholder ID#

OPTIONAL – EXTENUATING CIRCUMSTANCES

Please advise of any extenuating circumstance that you would like us to consider.

☐ Loss of monthly income due to diagnosis or treatment

$ _____ / month

Anticipated time frame: from: _____ to: _____

☐ Significant out of pocket treatment related expenses

Amount unpaid medical bills: $ _____

Childcare/Eldercare expenses: $ _____

Diagnosis/Treatment related travel expenses: $ _____

☐ None

*I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT:

Patient Name OR Personal Representative (Print) | Signature

Relationship to Patient | Date

As a Personal Representative of the patient, or an Ordering Physician completing this application on my patient's behalf, my signature also certifies that I have explained to the patient the nature and purpose of this application and that the patient has consented to my completing the application on his/her behalf.

FOR INTERNAL USE ONLY

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