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, Labcorp® Plasma Complete™ 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**

*TESTING INFORMATION (TO BE COMPLETED BY PROVIDER)

☐ **OmniSeq® INSIGHT** ☐ **Labcorp® Plasma Focus™**

☐ **IntelliGEN® Myeloid** ☐ **Labcorp® Plasma Complete™**

***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.

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