

# 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, Labcorp Myeloid NGS, Labcorp Lymphoid NGS, Labcorp Pan-Heme NGS and Labcorp Plasma Complete™ 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)		ORDERING PHYSICIAN AND FACILITY INFORMATION (TO BE COMPLETED BY PROVIDER)	
<input type="checkbox"/> OmniSeq INSIGHT	<input type="checkbox"/> Labcorp Lymphoid NGS	*Office/Practice/Facility Name _____	
<input type="checkbox"/> Labcorp Plasma Complete	<input type="checkbox"/> Labcorp Pan-Heme NGS	*Account # _____	
<input type="checkbox"/> Labcorp Myeloid NGS		*Ordering Physician _____	
*ICD Code _____		*Phone _____	*Fax _____
<b>PATIENT INFORMATION</b>		*Email _____	
*Last Name _____	*First Name _____	MI _____	
*DOB (MM/DD/YYYY) _____	*Sex <input type="checkbox"/> F <input type="checkbox"/> M		
*Street Address _____	*Apt.# <input type="checkbox"/> *City _____		<b>PATIENT INSURANCE INFORMATION</b>
*State <input type="checkbox"/> *Zip Code _____	*Country _____		*Does the patient referenced have medical insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Phone _____	*Email _____		If "Yes", please list responsible party information: Face sheet and/or copy of insurance card – both sides <input type="checkbox"/> See attached
			*Insurance Carrier Name _____
			*Insurance Carrier Phone _____
			*Policyholder Name _____
			*Policyholder ID# _____
<b>* TOTAL GROSS ANNUAL HOUSEHOLD INCOME</b>		<b>OPTIONAL - EXTENUATING CIRCUMSTANCES</b>	
Estimated Gross Annual Household Income _____		Please advise of any extenuating circumstance that you would like us to consider.	
<input type="checkbox"/>	<b>Number of family members in household supported by above gross annual household income</b>	<input type="checkbox"/> Loss of monthly income due to diagnosis or treatment \$ _____ / month Anticipated time frame: from: _____ to: _____	
<i>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.</i>		<input type="checkbox"/> Significant out of pocket treatment related expenses Amount unpaid medical bills: \$ _____ Childcare/Eldercare expenses: \$ _____ Diagnosis/Treatment related travel expenses: \$ _____	
<b>* WHO SHOULD WE CONTACT WITH THE APPROVAL DECISION?</b>		<input type="checkbox"/> None	
Ensure contact information for patient and facility is filled in at the top of the form.			
<b>Check all that apply:</b>	<b>Preferred method of contact:</b>		
<input type="checkbox"/> Patient	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail		
<input type="checkbox"/> Practice	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Fax		
<b>* I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT:</b>			
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.