Variantyx Patient Assistance Program

Variantyx is dedicated to making genetic testing affordable and accessible to everyone with a medical need. For patients with commercial insurance who qualify for our Patient Assistance Program, out-of-pocket expenses are limited on a sliding scale based on household size and adjusted annual income relative to Federal Poverty Guidelines. For self-pay patients and those who do not qualify for the Patient Assistance Program, flexible payment options are available. Due to regulatory restrictions, beneficiaries of government-funded programs (e.g., Medicaid, Medicare, TriCare, Veterans Affairs) are not eligible to apply.

Patient Information

Last Name ____________ First Name ____________ MI ____ DOB (MM/DD/YYYY) ____________

Street Address ____________ Apt # ____ City ____________ State ____ Postal code ____________ Country ____________

Phone ____________ Email ____________

Preferred method of contact ☐ Phone ☐ Email ☐ Mail

Household Size and Annual Adjusted Income Details *(fields in this section marked with an asterisk (*) are required to assess eligibility)*

____________ *** Number of family members in household supported by above gross annual household income (including the patient)**
Must be filled out to process form

*** Estimated Annual Household Gross (Pre-Taxed) Income**

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Patient Must Provide Documentation

Variantyx must receive confirmation of adjusted annual household income before approving assistance. Adjusted annual income is pre-taxed value including the total wages, social security, pension/ retirement, and other forms of income for all members of the household.

Please provide the patient/ guardian's most recent federal tax return or last two pay stubs. If you are unable to submit proof of income documentation, briefly describe below your income source(s) and why your tax return and/or pay stubs are not available:

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I Hereby Acknowledge the Above Information is True and Correct:

I hereby certify that the information provided above and the documentation I provide to Variantyx are true and accurate. I understand and agree that Variantyx reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional information. I also certify that I do not carry any US federal or state-funded health insurance.

Patient Name OR Personal Representative (Print) ____________ Signature ____________

Relationship to Patient ____________ Date ____________

Return Signed Form To Attn: *Client Services*

Fax: 617-433-5024 Mail: 1671 Worcester Road, Suite 300 Framingham MA 01701

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