Variantyx Patient Assistance Program

Variantyx is dedicated to making comprehensive genomic testing affordable and accessible to all patients with a medical necessity. Individuals with commercial insurance, might be eligible for our Patient Assistance Program, based on a sliding scale determined by household size and total gross annual income relative to Federal Poverty Guidelines. To evaluate eligibility, we consider the total household income for all members, including gross salary, unemployment or disability compensation, Social Security benefits, public assistance, and other assets such as retirement or investment dividends. The patient's financial responsibility is determined by the insurance company. It will be detailed in the Explanation of Benefits (EOB) provided by your insurance carrier; please note that the EOB is a statement of coverage and does not constitute a bill. Variantyx will subsequently issue an invoice based on the member's financial responsibility. For patients who qualify for our Patient Assistance Program, the approved discount or adjustment is applied to each individual test, and your final bill will be reduced according to the sliding scale listed in the table:

Percentage of household income relative to federal poverty guidelines*	Genomic Unity® Testing
0-200%	0
201%-400%	$150
401%-500%	$300
501-600%	$500
>600%	Please contact us

NOTE: For self-pay patients or those who do not qualify for the assistance program, flexible payment options remain available; however, please note that due to regulatory restrictions, beneficiaries of government-funded programs such as Medicare, Medicaid, and TRICARE are not eligible for this specific program.

Patient Information

Full Name | MI | Date of Birth (MM/DD/YYYY)

Street Address | Apt# | City

State | Postal Code | Country

Phone | Email

Preferred method of communication: ◯ 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):

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

Must be filled out to process form

Attestation

By signing below, I certify that all information provided in this application is accurate and complete. I authorize Variantyx, Inc. to verify these details for the sole purpose of assessing financial eligibility, which may include a request for supplemental documentation. I understand that if I am deemed ineligible for financial assistance, I will be notified and billed for the remaining balance. I agree that Variantyx reserves the right to audit the information provided, or to modify and terminate this assistance program and its associated forms at any time without prior notice. Finally, I certify that I will not seek reimbursement or credit for this testing from any third-party payer, including private insurance, government programs, or other financial assistance sources.

Patient Name or Personal Representative:

Signature:

Relationship to Patient:

Date:

Please return the signed form to our Patient and Family Relations team at Family.Relations@variantyx.com