Patient Assistance Program
Mail: ES Labs, 145 E. Badger Road Madison, WI 53713
Fax: 844-870-8875
Email: help@exactsciences.com

PATIENT ASSISTANCE FOLLOW UP

Dear [Patient First Name],

This letter is a follow up to your recent inquiry about financial assistance. While some restrictions may limit whether we can offer assistance, we need additional information from you as part of the application process.

You indicated that the amount(s) we billed you (or will bill you) for our testing services present an economic hardship to you. Attached is the disclosure form and application. You will need to provide financial information to help us determine whether you are eligible for assistance.

If you have any questions, please call our Billing Customer Care Center at 866-267-2322.

Thank you,

The laboratories of Exact Sciences

Patient Assistance Program
Mail: ES Labs, 145 E. Badger Road Madison, WI 53713
Fax: 844-870-8875
Email: help@exactsciences.com

Patient Assistance Disclosure Form and Application

Patients applying for assistance must complete and send in this form with supporting documentation.

Patient Name (First and Last): _____

Date of Birth (MM/DD/YYYY): _____

Patient's Mailing Address: _____

Telephone: _____ Preferred Language (circle one): SPANISH - ENGLISH

Section 1
Please provide at least **ONE** of the documents listed below:

a. A copy of last year's W2 tax form.

b. A copy of last year's Federal or State tax return (just the page(s) showing gross (pre-tax) income).

c. A copy of your latest payroll statement or Social Security check.

d. A copy of unemployment earnings if you are unemployed.

e. Proof that you qualify for any county, state, or federal assistance program(s) based on your income (e.g., Medicaid, Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Home Energy Assistance Program, etc.). **If you are unsure of what programs might qualify, please call our Billing Customer Care Center at 866-267-2322.**

f. If the patient does **not** have any of the above documents, please describe the patient's financial need. The patient may still qualify for assistance.

Section 2
Please estimate the annual gross (pre-tax) income for the patient's entire household: $ _____
Number of people living in the patient's household: _____

Section 3
I certify that all information provided to the laboratories of Exact Sciences is true and complete. I understand that the laboratories of Exact Sciences reserve the right to verify all information submitted. I acknowledge that my application **does not** guarantee that I/the patient will receive financial assistance of any kind.

Signature of Patient/Parent/Guardian (or explain why the patient cannot sign): _____

Date: _____

PLEASE NOTE: If you cannot pay your full bill, we encourage you to request financial assistance before making any payment. If you do make a payment, we will not refund it. Various restrictions apply to Exact's ability to provide patient assistance of this kind, and availability of such assistance is limited. If you would like to discuss payment options, or have any other payment-related questions, please call our Billing Customer Care Center at 866-267-2322.