TEMPUS

Financial Assistance

Typical form response time is 5-7 business days:

billing@tempus.com

Fax: 800.893.0276

For immediate application results:

access.tempus.com

Phone: 800.739.4137

Please complete all fields

PATIENT INFORMATION

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Sex

Street Address, Unit	City	State	Zip

Do you have health insurance? Yes No	Primary Method of Contact (Email Address)	Secondary Method of Contact (Phone Number with Area Code)

Estimated Gross Annual Household Income	Number of Family Members in Household (supported by the gross annual household income, including patient)

ORDERING PHYSICIAN & INSTITUTION INFORMATION

Institution (the name of the hospital or practice where you are being treated)
Ordering Physician's Name

EXTENUATING CIRCUMSTANCES

Alimony and/or child support expenses > $1,000 per month	Currently enrolled in short or long term disability with your employer	None
Non-local travel for treatment (e.g. hotel, airfare) > $1,000	Credit card debt > $,5000	Other:
Supporting family member(s) outside of household	Medical expense > $5,000	
Qualified for charity care with my physician	Permanent loss of income due to diagnosis or treatment	

Please share any background you would like our financial assistance team to take into consideration when reviewing your application:

CONSENT TO APPLICATION

Patient
By signing and submitting this application, I am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate. I also consent to Tempus' use of the information to assess and/or verify eligibility for assistance. *When applicable, Tempus may disclose the information above, as well as any eligibility determination that Tempus makes, to a Tempus contracted reference laboratory for its use to assess and/or verify eligibility for its financial assistance program.*

Patient Representative
As a Personal Representative of the patient, my signature certifies that (1) I have the right to do so on the patient's behalf, (2) if possible, I've explained to the patient the nature and purpose of this application, (3) the information set forth above is, to the best of my knowledge, truthful and complete, and (4) I consent to Tempus' use of the information to assess and/or verify eligibility for assistance. *When applicable, Tempus may disclose the information above, as well as any eligibility determination that Tempus makes, to a Tempus contracted reference laboratory for its use to assess and/or verify eligibility for its financial assistance program.*

Full Name:	Phone:
Relationship to Patient:	Email:

Signature	Date

By signing, you are indicating that all knowledge is correct to the best of your ability. If the provided information proves to be inaccurate, Tempus and/or Tempus contracted reference labs reserves the right to revoke financial assistance.