TEMPUS

Financial Assistance

Please complete all fields.

Typical form response time is 5-7 business days.

billing@tempus.com
f: 800.893.0276

For immediate application results:

access.tempus.com
p: 800.739.4137

PATIENT INFORMATION

Last Name	First Name	DOB (MM/DD/YYYY)	Biological Sex

Address (Street, 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: (REQUIRED - Numerical values only)	Number of family members in household supported by the gross annual household income, including the patient (REQUIRED):

Do you have any of the plans listed here? ☐ Yes ☐ No

BCBSNC (Blue Cross Blue Shield North Carolina), BCBSSC (Blue Cross Blue Shield South Carolina), BCBSVT (Blue Cross Blue Shield Vermont), CBC (Capital Blue Cross), CareSource OH/WV/KY/NC

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

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am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate.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	Today's Date (MM/DD/YYYY)

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.