TEMPUS

PATIENT FINANCIAL ASSISTANCE FORM

Online application available at:	Please sign and return to:
access.tempus.com	**Email:** orders@tempus.com **Fax:** 708.575.1789

PATIENT INFORMATION

Last Name	First Name	Date of Birth (mm/dd/yyyy)	Sex

Street Address, Unit	City	State	Zip

Do you have health insurance	Preferred Method of Contact, Please Choose One
☐ Yes	☐ Email Address: _____
☐ No	☐ Phone Number (with area code): _____

ORDERING PHYSICIAN & INSTITUTION

Institution (name of hospital or practice where you are being treated)
Ordering Physician

EXTENUATING CIRCUMSTANCES

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

Extenuating Circumstances

- ☐ Alimony and/or child support
- ☐ Non-local travel for treatment (e.g. hotel, airfare)
- ☐ Supporting family member(s) outside of household
- ☐ Qualified for charity care with my physician
- ☐ Short or long-term disability
- ☐ Significant credit card debt
- ☐ Significant medical expenses
- ☐ Permanent loss of income due to diagnosis or treatment
- ☐ Temporary 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am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate.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.

☐ **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.

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 reserves the right to revoke financial assistance.