TEMPUS PATIENT FINANCIAL ASSISTANCE FORM

FOR IMMEDIATE APPLICATION RESULTS:
Online: access.tempus.com *or* **Phone:** 800.739.4137

FORM RESPONSE TIME: 5-7 BUSINESS DAYS
Email: billing@tempus.com *or* **Fax:** 708.575.1789

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	Primary Method of Contact	Secondary Method of Contact
Yes No	Email Address: _____	Phone Number (w/ 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

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

Ordering Physician

EXTENUATING CIRCUMSTANCES

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 your 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am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate.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.

☐ **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.

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