

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
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 insurance plans listed here? Yes No		BCBSNC (Blue Cross Blue Shield North Carolina), BCSSC (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	Currently enrolled in short or long term disability with my employer	None
Non-local travel for treatment (e.g. hotel, airfare) > \$1,000	Credit card debt > \$5,000	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		
<p><i>By signing below, I attest that the following statements are true. If I am the patient's legally authorized representative, I make these statements on behalf of the patient.</i></p> <p>All information on this form is true and complete and I have consented to the genetic testing ordered by my provider. Tempus and its reference labs may use and disclose my information to assess and validate my eligibility for financial assistance, bill my insurance, act as my representative to appeal any denial of benefits, and request additional financial or medical records to verify my income or support an appeal. Tempus' Notice of Privacy Practices (at https://www.tempus.com/tempus-privacy-and-compliance-policies/) explains how my health information and specimens may be used, including in de-identified form. I may use that website to opt-out of certain secondary uses of de-identified data and understand that doing so will not impact my eligibility for financial assistance.</p>		
Full Name	Phone	
Relationship to Patient (Parent, Guardian, Legal Representative)	Email	
Signature	Today's Date (MM/DD/YYYY)	

Financial assistance may be revoked if the provided information is inaccurate.