18000 W. 99th St. Suite 100, Lenexa, KS 66129
Phone: 1-844-878-4723 ext 2
Fax: 888-224-3499
TGIBilling@tgi.eurofinsus.com

Financial Assistance Application

eurofins | Transplant Genomics

PATIENT INFORMATION		
Patient Name:		
Date of Birth:	Social Security Number:	
Spouse Name (or Parent(s)/Guardian(s) Name(s) if Patient is a Minor):		
Date of Birth:	Social Security Number:	
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:
Employed: No Yes If Yes, Employer Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

INCOME INFORMATION		
Please provide the income for each of the following persons in your household.		
Patient Is a Minor. The income Information is for the patient's parents or guardians.		
Patient (Or parent)	$	Per: Hour Week Month Year
Spouse (Or parent)	$	Per: Hour Week Month Year
Total Yearly Family Income: $		
Please Provide the Number of persons in the patient's household (Including the Patient):		
Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc	$	
Other Extenuating Circumstances: Please explain any other extenuating circumstances:		

INCOME VERIFICATION: Please provide any of the following types of documentation to support your eligibility.		
IRS Form W-2	Paycheck Remittance	
Employer Verification	Bank Statements	Non-filing IRS letter
Proof of participation in Government Assistance Programs (WIC, food stamps, housing assistance, Medicaid)	Social Security, Workers' Comp or Unemployment Determination Letter	Physician documentation evidencing determination of financial need and discount provided by ordering physician practice

PATIENT OR RESPONSIBLE PARTY
I understand that I am applying for financial assistance, and I am aware that falsification of information on this Application may result in denial of financial assistance. By signing below, I attest that all information provided is true and factual to the best of my knowledge.
Signature:
Employee Signature: