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FOR GENERATIONS TO COME

Dear Patient,

Unilab is honored to be your healthcare provider's preferred laboratory. We are committed to supporting patients that experience financial hardships by offering discounts and flexible payment plans. Eligibility for financial assistance is determined based on your income and the U.S. Department of Health and Human Services poverty guidelines **www.HHS.gov**.

To apply for financial assistance for Unilab testing, please fill out the Financial Assistance Application Form and include a copy of one of the following documents: (please block out your social security number)

- Last year's W2 form(s)
- Last year's income tax return
- Most recent pay stub
- Proof you are eligible for local, state, or federal assistance program(s)

Your eligibility is based on the information you provide in this form and the documentation you submit. Submit completed form and documentation to financialassistance@unilabfertility.com or fax it to 954-533-1283. If you have any questions, please contact Unilab Client Services at 833-4Unilab.

Health and Human Services Poverty Guidelines

Poverty Level	Unilab Discount
At or below poverty guideline	50% discount
Above 1x the poverty guideline, but below 2x	25% discount

Number of People Living in Household	Poverty Guideline
1	$13,590
2	$18,310
3	$23,030
4	$27,750

Add $4,720 to each additional person living in the household

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Financial Assistance Application Form

Patient's Name (First and Last) _____ Date of Birth_____

Phone Number_____ Ext _____

E-mail Address _____

Address _____Suite/Bldg_____

City_____State_____Zip_____

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?

☐ Yes – You are financially responsible for payment

☐ No – Please fill out the form below

2. Is any source, other than the patient, legally responsible for the patient's medical bills (Medicaid, welfare, guardian, supplemental insurance)?

☐ No – Proceed to question 3

☐ Yes – Please provide the following information:

Insurance Company _____

Address _____

Member Name _____

Member ID _____

3. What are the patient or legal guardian's monthly household resources?

Salary_____

Social Security_____

Welfare Payment _____

Family Contribution_____

Cash_____

Other_____

3. How many people are currently living in the household?

Adults _____

Children _____

Patient Acknowledgment

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I also authorize the release of all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified and Unilab will bill me. I hereby acknowledge that I am neither related to or employed by the provider who ordered the testing.

Patient/Legal Guardian's Signature_____Date _____

Print Name_____

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