Myriad Financial Assistance Program Application
Uninsured Patients

The Myriad Financial Assistance Program ("MFAP" or "Program") is available for those patients who are uninsured and also meet the financial and medical requirements described below. Both applicants and their healthcare providers must complete their applicable sections in order for the patient to be eligible for the Program. Note: An incomplete request will delay processing.

UNINSURED PATIENTS – Please complete the information below:

- I certify that I do not carry any commercial health insurance or Federally-funded health insurance (i.e., Medicare, Medicaid, Tricare, Medicare Advantage).
- Gross annual household income: $_____
  As supporting documentation, please submit a copy of the first page of your most recent tax return (IRS **Form 1040, 1040A or 1040EZ**). If you are unable to submit a tax return, in the space provided below, briefly describe your income source(s) and why your tax return is not available:

- Number of family members in household supported by above income: _____
- I certify that the gross annual household income for the number of persons listed above is less than the MFAP Financial Criteria @: **www.myriadpro.com/mfap**

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Myriad Financial Assistance Program requirements. I understand and agree that Myriad Genetic Laboratories, Inc. reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to audit the information I have provided on this application.

_____

Patient Signature **Date**

_____

Printed Name **Date of Birth**

HEALTHCARE PROVIDER Section:

- I have submitted an accurate and complete Myriad Test Request Form (TRF)
- I understand this patient has no insurance coverage

As the medical professional providing health care to this patient, I hereby certify that the information provided by myself is true and accurate.

_____

Health Care Provider Signature **Date**

_____

Print Name

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