Dear Patient,

Please complete the following form and submit it along with your sample in order to apply for a reduced or waived fee due to financial hardship.

If available when your sample is being collected, please submit a copy of one of the following documents along with a completed form to show your current household income. You can always submit proof of income at a later time. When submitting 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)

Based on the information you provide, we will determine whether you meet the criteria for waiver of some or all of your current charges. Criteria is based on U.S. Federal Poverty guidelines published by the Health and Human Services (HHS).

HHS Guidelines:

Total Household Size (incl. unborn child)	Annual Household Income Equal to or Less than [2,3]		
1	$ 49,960	$ 37,470	$ 24,980
2	$ 67,640	$ 50,730	$ 33,820
3	$ 85,320	$ 63,990	$ 42,660
4	$ 103,000	$ 77,250	$ 51,500
5	$ 120,680	$ 90,510	$ 60,340
6	$ 138,360	$ 103,770	$ 69,180
7	$ 156,040	$ 117,030	$ 78,020
8	$ 173,720	$ 130,290	$ 86,860
	$149 per test	**$99 per test**	**$0 per test**

As an alternative, if you had no income within the past year, you should provide us a notarized letter stating you are currently unemployed, and you did not file federal or state income taxes the previous year.

Compassionate Care applies after insurance or medicare billing has been exhausted. You may receive an EOB from your insurance company during the billing process. The EOB you may receive from your insurance is NOT a bill.

If you have questions, please call us at 1-844-384-2996 or email insbilling@natera.com.

Compassionate Care
Patient Financial Assistance Application

Please complete all information and attach the required supporting documentation. Patient signature is required.

Patient Name:	
Patient Date of Birth:	**Phone Number:**
Address:	City, State, Zip:
Email:	

1. Does the patient have sufficient resources to pay for testing and/or deductible and coinsurance?
    a. Yes – You are financially responsible for payment.
    b. No – Complete form below.
2. Other than the patient, is any source legally responsible for the patient's medical bills (e.g. Medicaid, guardian, local welfare agency, or insurance program)?
    a. Yes – Provide information below.
    b. No – continue to question #3.

Insurance Company Name:
Insurance Address:
Member I.D.:
Other source:

3. Patient/legal guardian's monthly resources:

Salary	$
Social Security	$
Welfare Payment	$
Family Contribution	$
Income from Savings Accounts, CD's, etc.	$
Other	$
Total:	$
Number of adults in household:	**Number of children in household *(includes unborn child)):***

I hereby acknowledge the above information is true and correct according to the best of my knowledge and belief. I 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 by phone or email, and Natera will bill me. I hereby acknowledge I am neither related to nor employed by the physician who ordered the testing.

Patient/legal guardian's Signature: **Date:**

Print Name:

FOR OFFICIAL USE ONLY:					
Case Number	*Pt. Resp.*	*Approved*	*Denied*	*Rep. Name*	*Notes*