Patient Financial Assistance Program

SkylineDx is committed to providing all patients with access to the Merlin™ test as it may help with important medical decisions. We understand the financial challenges and hardships healthcare and diagnostic testing may cause. To assist with these costs, SkylineDx has implemented programs for those that may need financial assistance and will gladly work with you to see if you may qualify. The SkylineDx Financial Support Program provides financial assistance for both eligible uninsured and commercially insured patients with financial needs.

Received an Explanation of Benefits (EOB)?

Your insurance company may send an Explanation of Benefits (EOB) stating that SkylineDx has submitted a claim. This is NOT a bill. The billing process between SkylineDx and your insurance company is ongoing and additional coverage may still be provided. If you receive a reimbursement check from your insurance company, please do NOT cash it and contact SkylineDx directly as this may affect your eligibility for financial assistance.

If you have questions regarding your SkylineDx bill, EOB, a check, or if you would like to discuss your eligibility for financial assistance; **please contact the SkylineDx Patient Care Team rather than your healthcare provider. We are here to help at 1.858.886.7907, option 2 or billing@skylinedx.com.**

SkylineDx is committed to providing access and financial assistance to all of our patients. The out-of-pocket costs for most patients can be reduced to no more than $100 after satisfying all eligibility requirements.

APPLY FOR SKYLINEDX PATIENT FINANCIAL ASSISTANCE

INSTRUCTIONS

1. Complete the application:
2. Include proof of income documents. Examples: IRS 1040 or W-2
3. Sign and date the application form.
4. Send completed application and proof of income documents to:

   SkylineDx USA, Inc.
   DEPT LA 25502
   Pasadena, CA 91185-5502

   or fax to: 402-204-8371

PATIENT INFORMATION

LAST NAME FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP

ORDERING HEALTHCARE PROVIDER

HOUSEHOLD INFORMATION

NUMBER OF PEOPLE IN HOUSEHOLD (INCLUDING DEPENDENTS)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

ESTIMATED TOTAL ANNUAL HOUSEHOLD INCOME $ _____

PROOF OF INCOME INFORMATION

PROOF OF TOTAL HOUSEHOLD INCOME **INCLUDED** (SELECT ONE)

☐ IRS ☐ 1040 ☐ W-2 ☐ Other _____

☐ **I certify that I am a permanent resident of the United States.**
U.S. RESIDENCY INCLUDE PUERTO RICO AND US TERRITORIES

CONSENT TO APPLICATION

Patient

By signing and submitting this application, I am certifying that all information provided is truthful and complete and I understand that financial assistance may be withdrawn if the information is inaccurate. I also consent to SkylineDxs' use of the information to assess and/or verify eligibility for assistance.

Patient Representative

As a Personal Representative of the patient, my signature certifies that (1) I have the right to do so on the patient's behalf, (2) if possible, I've explained to the patient the nature and purpose of this application, (3) the information set forth above is, to the best of my knowledge, truthful and complete, and (4) I consent to SkylineDxs' use of the information to assess and/or verify eligibility for assistance.

By signing below, I confirm that all provided information is accurate to the best of my ability. I acknowledge that SkylineDx reserves the right to revoke financial assistance if any information is found to be inaccurate. Additionally, I certify that I have read in full, understand, and agree to the terms outlined in the Patient Declaration and Authorization Statement.

Full Name: _____ **Phone:** _____

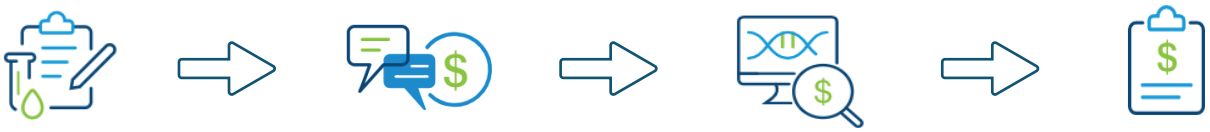
Relationship to Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

(For Internal SkylineDx Use Only) ACCOUNT NUMBER:_____ Approved ☐ Yes ☐ No Date:_____

Patient Financial Assistance Program

Reimbursement & Financial Support Process



After consulting with you, your provider will order the Merlin test through SkylineDx.

SkylineDx processes your information and submits a claim with your insurance company.

Your insurance will send an explanation of benefit (EOB), which is NOT a bill.

SkylineDx will send an application for financial assistance if there are any out-of-pocket costs.

Application Declarations

I verify that the information provided in this application is complete and accurate. I understand that my financial assistance will terminate if the SkylineDx Patient Financial Assistance Program becomes aware of any fraud or misrepresentations by me. I understand that SkylineDx reserves the right at any time and without notice to modify the application form; to modify or discontinue this or any program; and to terminate financial assistance. I understand that completing this application does not ensure that I will qualify for financial assistance. I certify that I am a U.S. resident whose gross household income is no more than 400% of the federal poverty level and that I do not have the ability to pay for the full cost of my diagnostic test. I also certify that I do not have other sufficient financial resources or assets to pay for the test requested or that paying for the test from my own resources or assets would cause me financial hardship.

Applicant Authorizations

I authorize SkylineDx, TELCOR (its third-party billing company) and their respective affiliates and agents (collectively, "SkylineDx") to use and/or disclose among SkylineDx the information on this application to assess my eligibility for participation in the financial assistance portion of the SkylineDx Patient Financial Assistance Program, including the audit of my medical records and/or by contacting me directly to confirm my eligibility and matters related to such program. I understand that this assistance is temporary and that SkylineDx Financial Assistance Program may be discontinued or changed at any time. I understand that SkylineDx will use my personal information in connection with the operation of the SkylineDx Financial Assistance Program and issues related to such program, including verifying statements made by my physician and myself in connection with my enrollment in the financial assistance program. I authorize my physician to disclose individually identifiable health and medical information to SkylineDx solely for the purposes of my participation in SkylineDx Financial Assistance Program. I understand that if I refuse to sign this authorization, I will not be able to participate in the financial assistance portion of SkylineDx Financial Assistance Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my future insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to SkylineDx. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed but will not affect disclosures made before that time. This authorization expires at the end of my participation in SkylineDx Financial Assistance Program or if SkylineDx does not approve my application for participation in the financial assistance portion of the SkylineDx Financial Assistance Program.