Veracyte Access Program

PROGRAM DETAILS

Because our testing may resolve important medical decisions, Veracyte is committed to providing all patients with access to our innovative and actionable genomic tests, regardless of their personal financial situation.

+ For Medicare patients, there is no copayment
+ For privately insured patients, copay is determined by the individual plan
+ The Veracyte Access Program provides financial support for both uninsured and commercially insured patients with financial need

If you have any questions regarding your Veracyte bill, insurance Explanation of Benefits (EOB) or eligibility, **please contact a Veracyte Customer Care representative rather than your healthcare provider.**

We are here to help at **844.464.LUNG (844.464.5864)** or **support@veracyte.com**

To learn more about Envisia, visit **lung.veracyte.com/envisia**.

VERACYTE ACCESS ELIGIBILITY FOR U.S. RESIDENTS*

Patient's household† income‡ must be less than these amounts to qualify for **100% reduction**§	
Household of 1 person	**$48,240**
Household of 2 people	**$64,960**
Household of 3 people	**$81,680**
Household of 4 people	**$98,400**
Add **$16,720** for each additional person	

Patient's household† income‡ must be within these amounts to qualify for **75% reduction**§	
Household of 1 person	**$48,241–$60,300**
Household of 2 people	**$64,961–$81,200**
Household of 3 people	**$81,681–$102,100**
Household of 4 people	**$98,401–$123,000**
Add **$20,900** for each additional person	

* Non-U.S. residents are not eligible for assistance. Household incomes stated apply to 48 contiguous states and DC. HI and AK thresholds differ.
† Number of dependents and personal exemptions claimed for tax filings.
‡ Based on all income in the prior calendar year by any source before deductions.
§ Relates to what percent of the payment due is reduced.

Detach here

Apply for **Veracyte Access**

Submit application within 12 months of Veracyte test date to ensure eligibility.

INSTRUCTIONS

1. Complete the Veracyte Access application at right.
2. Sign and date the Veracyte Access application.
3. Send application and documents to:

   Veracyte Access Program
   6000 Shoreline Court, Suite 300
   South San Francisco, CA 94080
   or fax to 650.243.6388

ABOUT THE PATIENT

LAST NAME .... FIRST NAME ....

STREET ADDRESS .... APT. .... CITY .... STATE .... ZIP ....

PHONE (   )   -   DATE OF BIRTH (mm/dd/yyyy) .... NAME OF ORDERING PHYSICIAN ....

ABOUT THE PATIENT'S HOUSEHOLD

Number of people in the household, including dependents

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other .... Gross annual household income ....

I understand that I am providing written permission for Veracyte, Inc. to obtain information from financial reporting agencies or other sources to verify my eligibility for the Veracyte Patient Access Program. I authorize Veracyte to obtain such information solely to determine Patient Access Program eligibility.

If I do not have insurance, I certify that I am not eligible for Medicare, Medicaid or any other government health insurance and will not seek reimbursement from any insurance carrier or government agency for fees waived by Veracyte, Inc.

I certify that the information provided is true and accurate. I have read and understand the Veracyte Access Program requirements. I understand and agree that Veracyte, Inc. reserves the right at any time and without notice to modify or terminate this Program and to audit the information provided on or enclosed with this application.

PATIENT SIGNATURE .... DATE ....

6000 Shoreline Court, Suite 300, South San Francisco, CA 94080 **T** 844.464.LUNG (844.464.5864) **T** +1.650.243.6335 (International) **F** 650.243.6388 **E** support@veracyte.com

The Envisia Genomic Classifier test is available as part of Veracyte's CLIA-validated laboratory-developed test (LDT) service. This test has not been cleared or approved by the FDA.

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