PROMETHEUS®
Therapeutics & Diagnostics
For the person in every patient

PROMETHEUS® Links®
FINANCIAL ASSISTANCE APPLICATION FORM

INSTRUCTIONS: COMPLETE ALL SECTIONS. USE N/A if section not applicable

ACCOUNT NUMBER: _____ _____ _____ ______ _____ _____

PATIENT INFORMATION

Patient Full Name:	Social Security Number:
Guarantor's Full Name:	Relationship to Patient:
Address:	City: State: Zip:
Phone Number:	Date of Birth:
Number of members in household / family unit: (based on most recent Tax Return)	U.S. Resident (Including Puerto Rico and U.S. Territories): ❑ Yes ❑ No

Patient's annual gross household /family unit income:

$____________________
(Your income before taxes & deductions)

Must provide a copy of your most recent federal tax return (Form 1040)
☐ Other Supporting Documents – please describe below

____

____

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 LINKS® program becomes aware of any fraud. I understand that Prometheus 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 I do not have the ability to pay for my diagnostic test and am a U.S. resident, 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 Prometheus, Quadax (third party billing company) and their respective affiliates and agents (collectively, "Prometheus") to use and/or disclose among Prometheus the information on this application to assess my eligibility for participation in the financial assistance portion on the LINKS® 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 LINKS® may be discontinued or changed at any time. I understand that Prometheus will use my personal information in connection with the operation of the LINKS® 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 Prometheus solely for the purposes of my participation in LINKS®. I understand that if I refuse to sign this authorization, I will not be able to participate in the financial assistance portion of LINKS®, 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 Prometheus. 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 LINKS® or if Prometheus does not approve my application for participation in the financial assistance portion of the LINKS® program.

I certify that I have read the Patient Declaration and Authorization Statement in full and that I understand and agree to the terms stated therein by signing below.

Patient's Signature	Date Signed (required)
Guarantor's Signature	Date Signed (required)

This document is the proprietary and confidential property of Prometheus Laboratories Inc. and may not be duplicated or altered without the prior written approval from the Compliance Group.