

Financial Assistance Application



BioReference Health, LLC formerly known as BioReference Laboratories, Inc., is pleased to help you with your clinical testing needs. We understand testing can be expensive so we offer a Financial Assistance Program (FAP). To help us know if you qualify for this program please complete the application below. **To avoid any delays, make sure to fill in all fields.**

PLEASE NOTE: Financial assistance is only for testing that is billed through insurance. Governmental health plans and some commercial health plans will not allow BioReference Health, LLC to offer financial assistance. If you are covered by any governmental health insurance such as Medicare, Medicaid, Managed Medicaid, Medicare Advantage, Tricare, Railroad, CHAMPUS and/or Federal BCBS, **please do not use this form**. To discuss other payment options or to find out if your commercial health plan allows for financial assistance, please contact us at **1-833-469-5227 or billings@bioreference.com**.

Patient Information (U.S. Residents Only)		
Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YYYY)
Email Address	Primary Phone Number	
Address	City	State
Accession Number or Account Number (if known)	Household Size	Household Income (pre-tax)

To see if you qualify for BioReference's Financial Assistance Program (FAP), we need to know your household size (the number of people who live in your home) and household income before taxes. Your total household income includes the following for ALL members of your household: Gross Salary (your wages), Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Pension/Retirement, Dividends/Interest, Rents/Royalties, Unemployment or Worker's Compensation, Alimony, and/or other Assets.

Your health insurance company will determine what your member financial responsibility will be for the BioReference testing. This amount will be listed on the Explanation of Benefits (EOB) letter your health insurance company sends you (the EOB letter is not a bill). BioReference will then bill you based on the EOB member financial responsibility. If you are approved for FAP, we will discount your final bill from BioReference by the percentage listed in the table below for which you are eligible. The table is based on the 2023 federal poverty guidelines and will be updated as federal guidelines change annually.

Household Size	Discount Based Annual Household Income				
	100%	95%	90%	80%	70%
1	\$ 14,580.00	\$ 18,225.00	\$ 21,870.00	\$ 25,515.00	\$ 29,160.00
2	\$ 19,720.00	\$ 24,650.00	\$ 29,580.00	\$ 34,510.00	\$ 39,440.00
3	\$ 24,860.00	\$ 31,075.00	\$ 37,290.00	\$ 43,505.00	\$ 49,720.00
4	\$ 30,000.00	\$ 37,500.00	\$ 45,000.00	\$ 52,500.00	\$ 60,000.00
5	\$ 35,140.00	\$ 43,925.00	\$ 52,710.00	\$ 61,495.00	\$ 70,280.00
6	\$ 40,280.00	\$ 50,350.00	\$ 60,420.00	\$ 70,490.00	\$ 80,560.00
7	\$ 45,420.00	\$ 56,775.00	\$ 68,130.00	\$ 79,485.00	\$ 90,840.00
8	\$ 50,560.00	\$ 63,200.00	\$ 75,840.00	\$ 88,480.00	\$ 101,120.00

We need some additional documents to confirm your household income. We are required by your health insurance company and applicable law to collect this information.

Along with this completed form, please send copies of two of the three types of supporting documentation:

- Type 1: Your most recent federal tax return (1040 or 1040EZ)
- Type 2: Your W-2 withholding statement
- Type 3: Your two, most recent and consecutive paystubs (2 paystubs count as one type of documentation)

Other Extreme Financial Situations –Please provide documentation for any other financial difficulties that you would like to take into consideration, such as:

- A copy of your bankruptcy status
- A summary of excessive medical bills
- The recent death or disability of a household earner

I hereby certify that the information provided above and the documentation I provide to BioReference are true and accurate. BioReference reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional documentation of income and financial need. I also certify I am not covered by a governmental insurance plan such as Medicare, Medicaid, Managed Medicaid, Medicare Advantage, Tricare, Railroad, CHAMPUS and/or Federal BCBS.

IMPORTANT: All information you send to us is handled safely and securely but only your first and last name, date of birth, and gross income information are needed on the documents you send us.

Please black-out other sensitive personal information such as social security number and net income.

Please send this completed form and your blacked-out supporting documents to us via one of the following secure options:

1. Fax to: **201-703-7130**
2. **billings@bioreference.com**
3. Mail to:

**ATTN: Billing / Customer Service BioReference Health, LLC.
481 Edward H. Ross Dr
Elmwood Park, NJ 07407**

AS A REMINDER: By applying for our financial assistance program, BioReference Health, LLC will bill your insurance.

Patient/Responsible Party's Signature	Date (MM/DD/YYYY)
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Financial Assistance Application



STEP 1: Complete Application and Prepare Supporting Documentation

Select two of the three types of supporting documentation from the previous page and black-out your sensitive personal information (i.e. social security number).

BioReference only needs to be able to view your first and last name, date of birth, and gross income. Here are some examples of how to black-out your documents:

Sample Company 123 Main St. Gaithersburg, MD 12345			EARNINGS STATEMENT			
EMPLOYEE NAME	SSN	EMPLOYEE ID	CHECK NO.	PAY PERIOD	PAY DATE	
John Doe				MM/DD/YY - MM/DD/YY	MM/DD/YY	
INCOME	RATE	HOURS	CURRENT TOTAL	DEDUCTIONS	CURRENT TOAL	YEAR-TO-DATE
GROSS WAGES			970.00	FICA MED TAX FICA SS TAX FED TAX		
YTD GROSS	YTD DEDUCTIONS	YTD NET PAY	CURRENT TOTAL	CURRENT DEDUCTIONS	NET PAY	

22222	Employee's social security number	OMB No. 1545-0008
b Employee identification number (EIN)	1 Wages, tips, other compensation	2 Federal income tax withheld
c Employee's name, address, and ZIP code	3 Social security wages	4 Social security tax withheld
	5 Medicare wages and tips	6 Medicare tax withheld
	7 Social security tips	8 Allocated tips
d Control number	9 Verification code	10 Dependent care benefits
e Employee's first name and initial	11 Nonqualified plans	12a
John Doe		12b
		12c
		12d
f Employee's address and ZIP code	13 Interest	14 Other
	15 State	16 State wages, tips, etc.
CA	CA	\$50,000
	17 State income tax	18 Local wages, tips, etc.
		19 Local income tax
		20 Locality name
		MU

W-2 Wage and Tax Statement 20XX
Form W-2 - For State, City, or Local Tax Department
Department of the Treasury - Internal Revenue Service



STEP 2: Send Your Completed Form and Prepared Documentation

Please send your documents via one of the following secure options:

1. Fax to: **201-703-7130**
2. Email to: **billingcs@bioreference.com**
3. Mail to:
ATTN: Billing / Customer Service BioReference Health, LLC.
481 Edward H. Ross Dr.
Elmwood Park, NJ 07407



Once you have sent your FAP materials, please contact us to make sure we have received your application and documentation.
1-833-469-5227



STEP 3: FAP Review, Explanation of Benefits (EOB) and Payment

Once your Financial Assistance Program (FAP) application and documents are reviewed, we will contact you to let you know if you're approved.*

Your health insurance company will send you your Explanation of Benefits (EOB) letter which may arrive before you have been contacted by BioReference about your FAP. You do not need to make any payment until BioReference has notified you and has sent you a BioReference bill.

If you are approved for FAP, the discounted percentage will be applied to the member financial responsibility listed on your EOB. For example, if your FAP discount percentage is 40% and your member financial responsibility on your EOB is \$300, you will receive a bill from BioReference for \$180.00.

	Explanation of Benefits (EOB) July 15, 20XX THIS IS NOT A BILL																											
Subscriber Information	Total of Claim(s)																											
First: John Last: Doe ID: Z12345678	Your current claim(s) total: \$350.00 Your insurance company paid: \$50.00 MEMBER RESPONSIBILITY Amount you are responsible for: \$300.00 <small>(Includes: copays, deductible, coinsurance, not covered or excluded services)</small>																											
Patient: John Doe ID: Z12345678																												
Medical Services Detail	Member Benefit																											
Claim #: 01-23456-78-90	Amount Your Provider May Bill You																											
Provider: ZEE O'PARE Date(s): 07/01/2019 Service: LABORATORY	<table border="1"> <thead> <tr> <th>Your Provider Billed</th> <th>Amount Allowed</th> <th>Member Savings</th> <th>Your Plan Paid</th> <th>Copayment</th> <th>Deductible</th> <th>Coinsurance</th> <th>Other Liability</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td>\$350.00</td> <td>\$100.00</td> <td>\$50.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$100.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$100.00</td> </tr> <tr> <td>Total for Claim # 01-23456-78-90</td> <td>\$350.00</td> <td>\$100.00</td> <td>\$50.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$100.00</td> <td>\$0.00</td> <td>\$300.00</td> </tr> </tbody> </table>	Your Provider Billed	Amount Allowed	Member Savings	Your Plan Paid	Copayment	Deductible	Coinsurance	Other Liability	TOTAL	\$350.00	\$100.00	\$50.00	\$0.00	\$0.00	\$100.00	\$0.00	\$0.00	\$100.00	Total for Claim # 01-23456-78-90	\$350.00	\$100.00	\$50.00	\$0.00	\$0.00	\$100.00	\$0.00	\$300.00
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\$350.00	\$100.00	\$50.00	\$0.00	\$0.00	\$100.00	\$0.00	\$0.00	\$100.00																				
Total for Claim # 01-23456-78-90	\$350.00	\$100.00	\$50.00	\$0.00	\$0.00	\$100.00	\$0.00	\$300.00																				

*You will receive a bill with the full amount if you are not eligible or all required documentation has not been received.