renalytix™ Right here, until kidney disease isn't.™

Patient Assistance Program Application

Application Date:	Test Date:
Patient Name:	Test Ordered:
Social Security/Green Card/ Visa No:	Date of Birth:
Address:	Phone Number:

Program Requirements

Income	The Patient Assistance Program may reduce the patient out of pocket cost and offer an interest free payment plan for qualified patients. Patients with Medicare, Medicaid or other government healthcare programs are not eligible. I certify that my gross annual household income is _____. The number of persons in my family household is _____. *Income verification documentation can include one of the following: your most recent tax return, W-2 or pay stub, a letter from your employer verifying income, unemployment benefit documentation or disability documentation. In the event these are not available, please check with Renalytix's billing department (include contact information)*
Residency	Patient must be a United States citizen or legal resident
Reasons for Requesting Financial Assistance	
Patient Statement	I certify that I am uninsured or lack the financial means to afford the test. I further certify that I am a United States citizen or legal resident. In the event either of these certifications is inaccurate, Renalytix reserves the right to collect the full amount owed by the patient for the test. Patient Signature: _____ Printed Patient Name: _____ Date: _____

Important: Proof of Income is mandatory. Supporting documentation for reviewing and approving patient assistance applications must be included with this form

Once Completed, please submit your application and proof of income documentation to:

By Mail:
RENALYTIX
PO BOX 2460
CAROL STREAM, IL 60132- 2460

By Fax:
801-210-6751

By Email:
Billing@Renalytix.com

For Office Use Only			
Original Patient Responsibility	$	Adjusted Patient Responsibility	$
Exception Approved?	Yes: _____ No: _____	Exception Reason:	
Approval Signature:		Print Name:	