Compassionate Care Application

Dear Patient,

Natera is proud to offer our Compassionate Care Program to ensure testing is accessible to you. Please complete the following application form and email to **compassion@natera.com**, or fax to **650-412-0834**. We recommend submitting the application after you receive your Natera bill for optimal processing.

Please submit a copy of one of the following documents along with this completed application. You can also submit proof of income at a later time to the email or fax listed above. We ask that you block out your social security number to ensure your data privacy.

- Last year's W2 form(s)
- Last year's income tax return
- Most recent pay stub

Based on the information you provide, we will determine whether you meet the criteria for a reduced patient responsibility rate. Criteria is based on U.S. Federal Poverty guidelines published by the Health and Human Services (HHS) as shown below in the chart. Please refer to the below table for the reduced patient responsibility rate you're eligible for based on your household size and annual income.

HHS Guidelines:

Household Size	Annual Gross Income		
1	$60,240	$45,180	$30,120
2	$81,760	$61,320	$40,880
3	$103,280	$77,460	$51,640
4	$124,800	$93,600	$62,400
5	$146,320	$109,740	$73,160
6	$167,840	$125,880	$83,920
7	$189,360	$142,020	$94,680
8	$210,880	$158,160	$105,440
Group Discount	**$149**	**$99**	**$0**

1. We will determine your eligibility based on your income and the U.S. Department of Health and Human Services poverty guidelines. The guidelines are updated annually and are available at the HHS website.
2. For families/households with more than 8 persons, add $4,540 for each additional person.

Compassionate Care applies after insurance or Medicare billing has been exhausted. You could receive an EOB from your insurance company during the billing process. The EOB you could receive from your insurance is NOT a bill.

If you have any questions, please email us at compassion@natera.com.

Patient Financial Assistance Application
Compassionate Care

Please complete all information and attach the required supporting documentation. Patient signature is required.

Patient Name | Patient Date of Birth (MM/DD/YY) | Case Number (From Invoice)

Phone Number | Address

City, State, Zip | Email

1. Does the patient have sufficient resources to pay for testing and/or deductible and coinsurance?

☐ Yes – Patient is financially responsible for payment.

☐ No – Complete form below.

2. Does the patient have any sources of funding for medical expenses such as health insurance or welfare? (e.g. Medicaid, guardian, local welfare agency, or insurance program)

☐ Yes – Provide information below.

☐ No – Continue to question #3.

Insurance Company Name | Insurance Address

Member I.D. | Other source

3. Patient/legal guardian's monthly resources

Salary	$
Social Security	$
Welfare Payment	$
Family Contribution	$
Income from Savings Accounts, CDs, etc.	$
Other	$
Total	$
Number of adults in household	
Number of children in household (includes unborn child)	

4. Please list any other outstanding medical expenses with corresponding documentation (i.e. statements, receipts).

Items	**Costs**
	$
	$
	$
	$
	$
	$
	$
	$

I hereby acknowledge the above information is true and correct according to the best of my knowledge and belief. I authorize the release of all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified by phone or email, and Natera will bill me. I hereby acknowledge I am neither related to nor employed by the physician who ordered the testing.

Patient/Legal Guardian's Signature | Print Name | Date (MM/DD/YY)

FOR OFFICIAL USE ONLY

Case Number	*Pt. Resp.*	*Approved*	*Denied*	*Rep. Name*	*Notes*