exosomedx a bio-techne brand

Driving Innovation. Personalizing Healthcare. Improving Lives.

The EPI Test | ExoDx™ Prostate (IntelliScore)

For Patients

PATIENT ASSISTANCE PROGRAM

The cost of the test may be reduced for patients who qualify for our Patient Assistance Program (PAP). To apply, patients must live in the United States or a US territory, have insufficient insurance coverage to pay for the test, meet certain income eligibility guidelines (the table below outlines the income eligibility guidelines to qualify for the PAP) and complete a PAP application.

Patients should expect to be notified of your status within two weeks of submitting the completed application form. If the application is approved, patients may elect to pay the full amount or opt to set up an interest free payment plan for up to 6 months. A minimum of $50 is required to enroll in the payment plan, which will be applied to the account balance. Missing a payment without making prior arrangements may jeopardize enrollment in the PAP.

To apply, please complete the PAP Application and submit via fax to 617-649-4308 or mail to Exosome Diagnostics, 266 Second Ave., Suite 200, Waltham, MA 02451.

Household Income Eligibility Guidelines for PAP*

Size of Household	Income Level 1	Income Level 2	Income Level 3	Income Level 4
1	$12,490	$24,980	$37,470	$49,960
2	$16,910	$33,820	$50,730	$67,640
3	$21,330	$42,660	$63,990	$85,320
4	$25,750	$51,500	$77,250	$103,000
Out-of-pocket cost	$100	$175	$250	$300

If you live in Alaska or Hawaii or have a household greater than 4 members, please call 844-396-7663, Option 3

If you do not qualify for the PAP Program, we offer an interest-free payment plan. Please call 844-EXOSOME, Option 3, to learn more.

*The 2019 poverty guidelines are in effect as of January 11, 2019. ExosomeDx follows the poverty guidelines as set by the U.S. Department of Health and Human Services. The current guidelines can be found at aspe.hhs.gov/poverty-guidelines. Income levels are subject to change at any given time.

Income Verification

To apply, patients submit a completed PAP application form and provide at least one supporting document in the form of pages 1 and 2 of your previous year's tax return (form 1040 or 1040EZ), wage and tax statements (W-2 or 1099), two recent paycheck stubs, social security, pension or railroad retirement statements (SSA-1099 or similar), statements of interest, or other income (1099-INT, 1099, 1099-DIV or similar forms).

CONTACT US:

To learn more about The EPI Test, please call or email us.

Mon–Fri: 9:00AM–5:00PM EST

844-EXOSOME (844-396-7663)

info.exosomedx@bio-techne.com

exosomedx.com

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PATIENT ASSESSMENT PROGRAM

Thank you for completing this patient assistance document from Exosome Diagnostics. We hope this program will help you get the testing you need. Please note that this program is available only to United States citizens or legal residents and residents of Puerto Rico and US Virgin Islands.

Patient Information

Last Name

First Name

DOB (MM/DD/YYYY)

Street Address Apt #

City State ZIP

Phone

Email Address

Ordering Physician

Office / Practice / Facility Name

Ordering Physician

Date of Test

Phone Email Address

City State ZIP

Household Income Verification
(One or More Is Required)

- ☐ Page 1 and 2 of prior year's tax return (form 1040 or 1040EZ)
- ☐ Wage and tax statements (W-2 or 1099)
- ☐ Two recent paycheck stubs
- ☐ Social security, pension or railroad retirement statements (SSA-1099 or similar)
- ☐ Two recent statements demonstrating disability or unemployment benefit income

Income Information

Annual Household Income

Number of persons in household (including applicant)

Patient Verification

By signing below, I certify that I cannot afford the test and that my answers and proof of household income documents are complete, true and accurate to the best of my knowledge. I understand that completing the application does not guarantee that I will qualify for the Patient Assistance Program and that Exosome Diagnostics may verify the accuracy of the information I have provided and may ask for more income or insurance information. I also acknowledge that Exosome Diagnostics reserves the right to modify or cancel the program at any time.

Patient Name or Representative (Print)

Relationship to Patient

Signature (Required)

Date

Return Completed Application With Supporting Documentation To

Fax: 617-649-4308 or

Mail: Exosome Diagnostics, Inc.
266 Second Ave., Suite 200
Waltham, MA 02451

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