FINANCIAL ASSISTANCE APPLICATION

Aligned with our belief that genetic testing should be accessible for all, GeneDx, LLC, offers flexible billing and payment options, including 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 return the application to billing@genedx.com. You may send a scanned copy or a picture of the completed form.**

PLEASE NOTE:

1. Financial Assistance is not available for all genetic testing services. Currently, financial assistance is not available for the following tests: URGb (GeneDx ultraRapid Genome Sequencing); TH78a (*GenomeXpress®* — Trio; TH78e (*GenomeXpress®* — Duo); TH78b (*GenomeXpress®* — Proband); 896a (*XomeDxXpress®* — Trio); 896e (*XomeDxXpress®* — Duo); and 896b (*XomeDxXpress®* — Proband).
2. Financial Assistance is considered on a case-by-case basis only. Financial assistance is not available to groups of patients. Each person requesting financial assistance for genetic testing must complete this form.
3. Financial assistance is for testing that is billed through insurance or for uninsured patients. To discuss other payment options or to find out if you qualify for financial assistance, please contact us at (888) 729-1206 or billing@genedx.com.
4. Financial assistance is available exclusively to patients and families residing in the United States.

Patient Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	
Email Address	Primary Phone Number	
Address	City	State
Account number from GeneDx Bill	Household Size	Household Income (pre-tax)

Select assistance type (choose one option)

○ Patient **DOES** have insurance (Out-of-pocket costs are discounted on a sliding scale)

○ Patient **DOES NOT** have insurance (Test prices are discounted on a sliding scale)

To see if you qualify for GeneDx'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 solely determine what your member financial responsibility will be for the GeneDx testing. This amount will be listed on the Explanation of Benefits (EOB) letter your health insurance company sends to you (the EOB letter is **not** a bill). GeneDx will then bill you based on the EOB member financial responsibility. Please note that if you qualify for financial assistance, the approved discount or adjustment amount is **applied to each individual test**, and we will discount your final bill based on the amount listed in the table below.

The table is based on the 2025 federal poverty guidelines and will be updated as federal guidelines change annually.

HOUSEHOLD SIZE	DISCOUNTED AMOUNT DUE BASED ON HOUSEHOLD INCOME				
	$0	$75	$150	$200	$250
1	$31,300	$46,950	$62,600	$78,250	$93,900
2	$42,300	$63,450	$84,600	$105,750	$126,900
3	$53,300	$79,950	$106,600	$133,250	$159,900
4	$64,300	$96,450	$128,600	$160,750	$193,800
5	$75,300	$112,950	$150,600	$188,250	$225,900
6	$86,300	$129,450	$172,600	$215,750	$258,900
7	$97,300	$145,950	$194,600	$243,250	$291,900
8	$108,300	$162,450	$216,600	$270,750	$324,900
9	$119,300	$178,950	$238,600	$298,250	$357,900
10	$130,300	$195,450	$260,600	$325,750	$390,900
11	$141,300	$211,950	$282,600	$353,250	$423,900
12	$152,300	$228,450	$304,600	$380,750	$456,900
13	$163,300	$244,950	$326,600	$408,250	$489,900
14	$174,300	$261,450	$348,600	$435,750	$522,900

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE GENEDX TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFIED AND GENEDX WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING. I UNDERSTAND AND AGREE THAT GENEDX LLC RESERVES THE RIGHT AT ANY TIME AND WITHOUT NOTICE TO MODIFY THE APPLICATION FORM; TO MODIFY OR TERMINATE THIS PROGRAM; AND TO AUDIT THE INFORMATION I HAVE PROVIDED ON THIS APPLICATION. I FURTHER CERTIFY AND AGREE THAT I WILL NOT SEEK REIMBURSEMENT OR CREDIT FOR THIS TESTING FROM ANY INSURER, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PROGRAM OR OTHER SOURCE OF FINANCIAL ASSISTANCE.

Patient/Responsible Party's Signature	Date MM/DD/YYYY

T: (888) 729-1206, (301) 519-2100 • F: (201) 421-2010 • billing@genedx.com • GeneDx.com