ARTERA

Financial Assistance Program Application

Please sign and return the completed application to billing@artera.ai. We will review and follow up shortly after submission.

FINANCIAL ASSISTANCE LEVELS:

Household Size	$0 cost to patient if household income is less than:	$95 cost to patient if household income is less than:	$190 cost to patient if household income is less than:	$285 cost to patient if household income is less than:
1	$46,950	$62,600	$78,250	$93,900
2	$63,450	$84,600	$105,750	$126,900
3	$79,950	$106,600	$133,250	$159,900
4	$96,450	$128,600	$160,750	$192,900
5	$112,950	$150,600	$188,250	$225,900

PLEASE PROVIDE YOUR INFORMATION BELOW:

Patient full name	
Date of birth	
Address	
City	
State	
Zip code	
Email address	
Phone number	
Ordering physician's name	
Household size	
Household income	
Extenuating circumstances	☐ Alimony and/or child support expenses > $1,000 per month ☐ Currently enrolled in short or long term disability with your employer ☐ Credit card debt > $5,000 ☐ Medical expense > $5,000 ☐ Qualified for charity care with my physician ☐ Permanent loss of income due to diagnosis or treatment ☐ Other _____

I hereby acknowledge the above information is accurate and complete to the best of my knowledge. I authorize Artera to verify the above details, including by engaging a third-party entity or requesting supporting documentation, solely for the purpose of assessing financial need. I understand that by applying for this program, I am not guaranteed financial assistance. I understand and agree that Artera 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.

Patient Signature	
Date	