Financial Assistance Program Application

The Artera Financial Assistance Program ("Program") is designed for qualifying patients who are uninsured or are insured under a commercial insurance plan. Patients insured by federal programs such as Medicare Part B, Medicare Advantage, Medicaid, Federal Employee Health Program, Tricare, Indian Health Service or any other federal programs are not eligible for the Program. **Please complete and sign the application below indicating that you would like to apply for the Program. Please return the completed application via email to billing@artera.ai. You may send a scanned copy or a picture of the completed form.**

To be eligible for the Program, certain criteria must be met. Therefore, we need to know your household size (the number of people who live in your home) and household income. Your total household income includes the following for ALL members of your household: Gross Salary (your wages before taxes), Unemployment Compensation, Disability and Workers 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.

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	$45,180	$60,240	$75,300	$90,360
2	$61,200	$81,600	$102,000	$122,400
3	$77,460	$103,280	$129,100	$154,920
4	$93,600	$124,800	$156,000	$187,200
5	$109,740	$146,320	$182,900	$219,480

A member of Artera's billing team will contact you after your application has been processed to let you know if you qualify for the program and what your out-of-pocket costs will be for the ArteraAI test under the Program. If you have any questions or concerns about your application, please contact the Artera billing department at billing@artera.ai.

PLEASE PROVIDE YOUR INFORMATION BELOW:

Patient Name (Last, First):	Date of Birth (MM/DD/YYYY):
Address:	City:
State:	Zip Code:
Primary Phone Number:	
Email Address:	
Physician's Name:	
Household Size:	Household Income:

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. I further certify and agree that I will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, or government program or other source of financial assistance.

Patient/Responsible Party's Signature:	**Date (MM/DD/YYYY):**