Tumor Profiling Financial Assistance Application

Please email this form to patientnavigator@carisls.com or fax to 866-479-4925.

PATIENT INFORMATION

Name (Last, First, Middle Initial)		Date of Birth
Phone	Email	
Street Address		
City	State	Zip

ORDERING PHYSICIAN AND FACILITY INFORMATION

Office/Institution Name	
Ordering Physician	
Physician Phone	Physician Email

HOUSEHOLD INFORMATION

Total Annual Gross Household Income

☐ $0-$9,999 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$39,999 ☐ $40,000-$49,999 ☐ $50,000-$59,999
☐ $60,000-$69,999 ☐ $70,000 - $79,999 ☐ $80,000-$89,999 ☐ $90,000-$99,999 ☐ $100,000-$109,999 ☐ $110,000-$119,999
☐ $120,000-$129,999 ☐ $130,000-$139,999 ☐ $140,000-$149,999 ☐ > $150,000

Number of persons in the household (include self)

REASON FOR FINANCIAL ASSISTANCE REQUEST

Prompt pay discounts and discounted payment plans are available. Call or email your Caris Patient Navigator for more information.

Phone: (888) 979-8669
Email: patientnavigator@carisls.com

I certify that the information I have provided in this form is accurate and complete. I authorize Caris Life Sciences to use my information to determine eligibility for financial assistance or as otherwise permitted by law. Submission of this form does not constitute approval or guarantee eligibly to receive discounted services. The guidelines for providing hardship assistance may change or the program may be discontinued without notice.

Patient Name (Print)	Signature	Date