Exhibit B

Financial Assistance Disclosure Form and Application

Name(Last,First): _____ DOB: _____ Phone: _____

Address: _____

City: _____ State/Province: _____ Zip Code: _____

Date of Application: _____ Date of Test(s): _____ Account # (if known): _____

Insurance Carrier Name: _____ Insurance Phone #: _____

Policyholder Name: _____ ID #: _____

Innovative Genomics has provided laboratory services, as requested by your referring provider. A claim for reimbursement for the services was submitted to your insurance provider, and the claim has been processed. In accordance with contractual and legal obligations of health benefit plans, Innovative Genomics has a responsibility to collect any amounts you are responsible for, including any copay, co-insurance, and/or deductible amounts. Innovative Genomics has adopted a Financial Assistance Program to work with patients whose circumstances prevent them from paying amounts owed as and when they are due or who cannot pay the full amounts owed and meet their other financial obligations for basic and necessary living expenses. Your eligibility for the Financial Assistance Program is based on your annual adjusted income and number of family members in your household.

Program Requirements:

*Patient assistance is based on the most recently published Federal Poverty Guidelines (2022 guidelines reproduced below). Combined household income must be less than or equal to 300% of the federal poverty guidelines. Other restrictions may apply (e.g., consent from applicable insurance provider). Please circle the row in the table below that describes your household's size and combined income. If more than 8 persons reside in your household, please indicate in the space provided the size and combined income of your household.

Persons in family/household	Proverty guideline
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630
For families/households with more than 8 persons, add $4,720 for each additional person.	

Please fill in the below information only if more than 8 persons reside in your household.

Persons in family/household: _____

Combined household income:

$ _____

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Supporting Documentation

To verify your income information above, please provide a copy of one (1) or more of the following:

- Most recent IRS tax return (1040) and/or Wage and Tax Statement (W-2);
- Check stubs for the past 30 days for all persons employed in the home and proof of all other income received in the past 30 days;
- Unemployment check stubs for the past 30 days and proof of all other income received in the past 30 days;
- Medicaid forms or cards;
- Social Security Disability or Survivor Benefits;
- Proof of bankruptcy settlement;
- Proof of catastrophic situations (death or disability in the family, divorce); and/or
- Other documentation that shows you would be unable to pay the amounts you owe and still be able to pay for other basic and necessary expenses.

Attestation

I hereby certify that the information provided by myself or my legal representative is true and accurate. I have read and understand the Program requirements listed above. I understand and agree that Innovative Genomics reserves the right at any time and without notice to modify the application form; to modify or terminate the Program; and to verify or re-verify the information I provide with this application. I further certify and agree that I have not received and will not seek reimbursement or credit for this testing from any insurer, health maintenance organization, government program or other source of financial assistance. I understand that I will be notified if I do not qualify for financial assistance. I acknowledge that I am neither related to, nor employed by, the healthcare provider ordering the test(s). I acknowledge and agree that Innovative Genomics may at any time require that I pay full price if it later determines that inaccurate information was provided.

_____ _____ / _____ / _____

Signature of Patient or Legal Representative Date (MM/DD/YYYY)

OFFICE USE ONLY

_____ APPROVED _____ DENIED _____ Initial _____ / _____ / _____ Date (MM/DD/YYYY)

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