Vectra® Financial Assistance CARE Program

PATIENT INFORMATION

FIRST NAME M.I. LAST NAME

DATE OF BIRTH (MONTH/DAY/YEAR) EMAIL ADDRESS

CELL/PRIMARY PHONE ALTERNATE PHONE

STREET ADDRESS CITY STATE ZIP

PATIENT CERTIFICATION

- If I do not have insurance, I certify I am not eligible for Medicare, Medicaid, or any other state or government health insurance and will not seek reimbursement from any insurance carrier or government agency for Vectra fees waived.
- If I have insurance, I certify that I will not seek reimbursement from any insurance carrier or government agency for Vectra fees that are my financial responsibility.
- I certify that the information contained in this application is correct to the best of my knowledge. I understand this information will not be used for any other purpose unless I give written consent, or to the extent necessary to document my eligibility under the Vectra Financial Assistance CARE Program.
- I certify I will notify the Vectra Financial Assistance CARE Program within 30 days if there is any change in my eligibility status with regard to income and health care coverage. I will provide documentation, including but not limited to personal financial records, which are necessary to verify the information contained in this application.
- By agreeing to Vectra testing, I authorize Vectra Billing to obtain a consumer credit report on me from a consumer reporting agency selected by Vectra Billing. I understand and agree that Vectra Billing may use my consumer credit report to confirm whether my income qualifies me for financial assistance. I further understand that this will be a soft credit inquiry and will not impact my credit in any way.
- If I qualify for financial assistance, I agree to provide Vectra Billing with any additional information or documentation that may be needed to confirm my qualification for the financial assistance program.

PATIENT SIGNATURE DATE

The Vectra Financial Assistance CARE Program reserves the right to modify or discontinue this program with respect to any patient or in its entirety, at anytime.

Please email this form to: billinghelp@myriad.com or FAX back to: 801-883-8965
Vectra Financial Assistance CARE Program | 1-877-743-8639
Vectra Billing | PO Box 581108 | Salt Lake City, UT 84158-1108

Español (Spanish)
Myriad Genetics, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-743-8639.

繁體中文 (Chinese)
Myriad Genetics, Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-743-8639。