



From PerkinElmer

NTD LABORATORIES, INC.
PATIENT ASSISTANCE PROGRAM

NTD will provide a discount from its usual and customary charge for its services on a sliding scale basis for individuals who are uninsured and meet our financial need standards.

- Uninsured includes persons with no insurance (including Medicaid coverage) whatsoever and persons with insurance, but whose insurance does not cover our services at all (including Medicaid).
- The financial need standards are noted in the table that we have provided. Patients are asked to sign and date an attestation form that they meet the Patient Assistance Guidelines to be eligible for this assistance.
- Patients should review the table and determine the amount of reduced payment by reference to gross (or adjusted gross) income and the number of persons in the household.
- The signed form should be provided, along with the reduced payment, in the envelope with the blood card sample.
- Payment may be made in the form of a check payable to NTD Labs or credit card information may be provided in the appropriate section of the blood card.



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APPLICATION FOR REDUCTION OF BILL UNDER PATIENT ASSISTANCE PLAN

Please fill out this form completely and sign below. Consult the table for the appropriate reduced payment amount depending upon your gross or adjusted gross income and the number of persons in your household. Please send a check or supply credit card information on the blood card, in the correct amount and include this form with your blood card in the envelope.

Patient Date of Birth: _____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____

Current Gross or Adjusted Gross Annual Income:

(Your may use your gross income which is what you are paid. If you know it, you may also use your adjusted gross income from your most recent tax return. Adjusted gross income would result in a higher discount.)

Current Gross or Adjusted Gross Annual Income for yourself: \$ _____

Current Gross or Adjusted Gross Annual Income for your spouse: \$ _____

Combined total from yourself and spouse: \$ _____

Number of dependents in household (including self) _____

Patient Signature _____ Date _____

*NTD Labs reserves the right to request a copy of your W-2 or paystub to verify income at a later date.