PATIENT FINANCIAL ATTESTATION FORM

Please complete all required information

Patient First Name _____ Last Name _____

Patient Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

TOTAL MONTHLY GROSS INCOME

Salary / Wages	$	Unemployment	$
Social Security	$	Pension / Retirement	$
Disability	$	Alimony / Child Support	$

Total Monthly Income $_____

I attest that the information provided on this application is complete and accurate. I understand that all personal identifying information obtained by CareDx in response to this application will be used by CareDx and its authorized agent(s) to administer the Program and will not be used or disclosed for any other purposes, except as may be required or permitted by applicable law. I also understand that CareDx reserves the right at any time and without notice to modify the application form or the eligibility criteria, modify or discontinue any or all aspects of the Program or terminate any assistance provided by the Program.

Patient's Signature _____ **Date** _____

Once you have completed the form, please send it to CareDx either by fax, e-mail or by mail.

Email to: PatientAdvocacy@caredx.com
Fax to: 415-287-1471
Mail to: CareDx Inc
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Brisbane, CA 94005