

Form not applicable for patients with US federal or state-funded health insurance (e.g., Medicaid, managed Medicaid, Tricare). Please contact Support at 650.460.2551 if you have federal or state-funded health insurance.

PATIENT INFORMATION *Shaded fields must be completed*

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	MI	Last Name	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address	Phone	# of People in Household	Annual Household Income (Pre-Tax)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	Apt / Unit / Suite	City	State
			Zip Code

ASSISTANCE LEVEL

If your total yearly pre-tax household income is less than the amounts below, depending on your household size, you may qualify for reduced pricing for the UNITY™ test. If your out-of-pocket financial responsibility is above the test costs below, we will cap it at a reduced price.

Income values are pre-tax and based on 2019 poverty guidelines: <https://aspe.hhs.gov/poverty-guidelines>. For households larger than 8, please contact our Customer Support.

# of people in household	\$0 test cost	\$149 test cost	\$299 test cost
(including current pregnancy)	if your total household income is equal to or less than	if your total household income is equal to or less than	if your total household income is equal to or less than
2	\$33,820	\$67,640	\$101,460
3	\$42,660	\$85,320	\$127,980
4	\$51,500	\$103,000	\$154,500
5	\$60,340	\$120,680	\$181,020
6	\$69,180	\$138,360	\$207,540
7	\$78,020	\$156,040	\$234,060
8	\$86,860	\$173,720	\$260,580

PATIENT ATTESTATION *Sign and date*

I hereby certify that the information provided above is true and accurate. I also certify that I do not carry any U.S. federal and state-funded health insurance (e.g., Medicare, Medicaid, Tricare, Medicare Advantage). I understand and agree that BillionToOne reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional information.

<input type="text"/>
Patient Signature
<input type="text"/>
Date

CLINIC INFORMATION *Shaded fields must be completed*

<input type="text"/>	
Clinic Name	
<input type="text"/>	<input type="text"/>
Clinic Phone	Clinic Fax
<input type="text"/>	
Clinic Address	

INSTRUCTIONS

Complete and place this form in the box along with the sample, or FAX it to **833.915.0146**.