



## NEOVARE™ FINANCIAL ASSISTANCE APPLICATION

Dear siParadigm Patron,

Thank you for your interest in our Neovare™ financial assistance program. siParadigm is committed to providing exceptional laboratory services, regardless of your ability to pay. We are also obligated to remain compliant with guidelines and regulations set forth by insurance companies.

Our billing department can offer solutions for uninsured or underinsured patients based on individual circumstances. We can offer prompt pay discounts and monthly installment payments and we have a financial assistance program.

We understand that financial difficulties can arise, and we are committed to assisting those in need. Please complete this form to apply for a financial hardship discount for the Neovare™ product. The total amount due will not exceed \$250, subject to qualification and approval.

Respectfully,  
siParadigm, LLC

Fap.billing@siparadigm.com

Call 1-888-599-5227 and choose the option for billing.

Mail to:  
siParadigm LLC  
25 Riverside Dr. Suite 2  
Pine Brook, NJ 07058

**Applicant Information:**

- Full Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- City, State, ZIP Code: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Case Number: \_\_\_\_\_

**Details of Hardship:** Please provide a brief explanation of your financial situation, including specific reasons for your hardship (e.g., job loss, medical expenses, or other financial burdens):

---

---

---

**Attachments:** Please attach the following documents to support your application:

- Proof of income (e.g., recent pay stubs or tax returns)
- Relevant medical bills (if applicable)
- Other supporting evidence of financial hardship

**Acknowledgment and Agreement:** By signing below, I acknowledge that this application is subject to review and approval. I certify that the information provided is accurate to the best of my knowledge. I agree to provide additional documentation if requested.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_