LYNX DX | MY PROSTATE SCORE 2.0

CARES Financial Assistance Application

MKTG-033, V2, 02/28/25

Need help? Call us at (844) 534-3510 | 8 a.m.-8 p.m. ET, Mon.-Fri.

Patient Information

First Name | Last Name | Date of Birth

Street Address

City | State | Zip | Telephone Number

Email Address (optional) | Provider Name (optional)

Insurance Provider and Policy/Member Number

Additional Information You Wish to Provide (optional)

Acknowledgment

I hereby acknowledge that:

- The above information is true and correct according to the best of my knowledge.
- Program availability is not guaranteed and may be limited or unavailable in certain states or certain health insurance plans.
- Income may be verified independently. Lynx Dx reserves the right to request documented proof of financial need. I should be prepared to provide financial documents as required.
- I authorize the release of any financial records necessary to verify the above information.
- I understand that submission of this application does not guarantee approval of financial assistance.

Patient or Responsible Party Signature | Date

Name (please print)

Submit your application using any option below:

Email	**Mail**	**Fax**
billing@lynxdx.com	Lynx Dx CARES P.O. Box 7027 Ann Arbor, MI 48107-7027	(844) 440-2407

Lynx Dx will contact you once your application is reviewed. In the meantime, do *not* yet pay your bill.