Dear siParadigm Patron,

Thank you for your interest in our 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, monthly installment payments and financial hardship which may adjust some or all of your out of pocket responsibility for our services.

Please contact our dedicated patient customer service representatives to discuss payment options or to see if you qualify for our Financial Assistance.

To apply for Financial Assistance please review the poverty guidelines attached, complete the FAP (Financial Assistance Application Form) and mail or email it to our office with your Case Number. A member of our team will contact you upon its receipt.

Fap.billing@siparadigm.com

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

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

2023 Financial Criteria (HHS Poverty Guidelines)

PATIENT RESPONSIBILITY AMOUNT
Patients with a household income up to the amounts shown below who meet all other eligiblity requirements will have a maximum out of pocket responsibility of the amount shown at the top of the column.

	1X Poverty: $0.00	2X Poverty: $0.00	3X Poverty: $100.00	4X Poverty: $250.00
Family Size				
1	$14,580.00	$29,160.00	$43,740.00	$58,320.00
Family Size				
2	$19,720.00	$39,440.00	$59,160.00	$78,880.00
Family Size				
3	$24,860.00	$49,720.00	$74,580.00	$99,440.00
Family Size				
4	$30,000.00	$60,000.00	$90,000.00	$120,000.00
Family Size				
5	$35,140.00	$70,280.00	$105,420.00	$140,560.00
Family Size				
6	$40,280.00	$80,560.00	$120,840.00	$161,120.00
Family Size				
7	$45,420.00	$90,840.00	$136,260.00	$181,680.00
Family Size				
8	$50,560.00	$101,120.00	$151,680.00	$202,240.00
Family Size				
9	$55,700.00	$111,400.00	$167,100.00	$222,800.00
Family Size				
10	$60,840.00	$121,680.00	$182,520.00	$243,360.00

siParadigm Financial Assistance Program Application

Please complete the information below for your healthcare provider-ordered testing at siParadigm:

Check one: I am applying for

☐ **Uninsured Assistance**: I do not have any medical health insurance. If I meet the low-income criteria, I understand that my cost for testing will be limited to $0.00 if my income is up to 2X federal poverty level (FPL); $100.00 if my income is 2-3X FPL; $295.00 if my income is 3-4X FPL.

☐ **Under-Insured Assistance**: I currently have medical insurance coverage with _____ and have supplied all currently policy information to my physician's office for submission with the test requisition form. If I meet the low-income criteria for my healthcare provider ordered test, I understand any out-of-pocket expense resulting from my medical insurance claim will be limited to the amount listed above under Uninsured Assistance.

Number of family members in household supported by the income listed below: _____

Household Annual Gross Income (AGI): $_____ (Note: the AGI includes the following for all members of your household; Gross Salary, Unemployment Compensation; Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc). As supporting documentation please submit a copy of the first page of your most recent tax return (IRS Form 1040, 1040A or 1040EZ) or documentation summarizing and supporting income such as a W2. If you are unable to submit income documentation, briefly describe your income source(S) and why your tax return is not available and why payment of this bill will result in a financial burden.

I hereby certify that the information provided by myself, or my legal representative is true and accurate. I have read and understand the siParadigm Financial Assistance Program requirements and understand that siParadigm LLC reserves the right at any time and without notice to modify the application form; to modify or terminate this program, and to audit the information I have provided on this application.

Date: _____ Patient/legal guardian Signature_____

Case #: _____Printed Name: _____