Helix

Patient Financial Assistance Program

STEP 1: PATIENT INFORMATION *(US RESIDENTS ONLY)*

First name	MI	Last name	Date of birth (MM/DD/YYYY)	Mobile phone

Email address	Employer (if applicable)	Household size	Household income (pre-tax)

Address	City	State	Zip

Patient's household income must be less than these amounts to qualify for 100% reduction

Test price will be waived if:

Household size	Income under
1	$62,600
2	$84,600
3	$106,600
4	$128,600
5	$150,600
6	$172,600
7	$194,600
8	$216,600

For households larger than 8, please contact our billing department at reimbursement@helix.com.
Income values are pre-tax and based on 2025 poverty guidelines (https://aspe.hhs.gov/poverty-guidelines)

STEP 2: PATIENT ATTESTATION

I hereby certify that the information provided above and the documentation I provide to Helix are true and accurate. I understand and agree that Helix 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. I also certify that I do not carry any U.S. federal or state-funded health insurance (i.e., Medicare, Medicaid, Tricare, Medicare Advantage).

Patient/guardian signature (required)	Printed name	Date (MM/DD/YYYY)

STEP 3: PATIENT MUST PROVIDE DOCUMENTATION

Helix must receive confirmation of patient's household income before providing patient assistance, including: wages, social security, pension/retirement, dividends/interest, rents/royalties, unemployment or worker's compensation, alimony, or other assets.

Provide the patient/guardian's most recent federal tax return, Form 1040.

If you are unable to submit income documentation, briefly describe below your income source(s) and why your tax return is not available: