Member Advance Notice Form for the Use of a Non-Covered Test from Foundation Medicine for UnitedHealthcare Members

Your physician or other health care professional has decided to order a non-covered test from Foundation Medicine in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your testing options and you have agreed to receive non-covered services from Foundation Medicine despite the potential increased out-of-pocket costs associated with that decision.[1]

UnitedHealthcare believes it is important you understand that you may have higher out-of-pocket costs when using Foundation Medicine for non-covered testing services based on your benefit plan. Please also note that if you receive non-covered services from Foundation Medicine, you may be responsible for the entire cost of the services.

If you have questions about the financial assistance and payment options available to you for the non-covered services you require, please contact Foundation Medicine at 1-888-988-3639 You can also confirm the coverage status of testing options by contacting UnitedHealthcare Customer Care at the telephone number on the back of your health plan ID card, or by logging onto myuhc.com® .

To be completed by the member's physician or other health care professional:

Physician/Health Care Professional Name	
Physician/Health Care Professional Tax ID #	
Member Name	
Member ID #	
Physician/Facility/ Healthcare Provider Name	Foundation Medicine, Inc.
Type of **Non-Covered Service** Participating Provider will Render (e.g. Lab, Dialysis)	Comprehensive genomic profiling using FoundationOne or FoundationOne Heme
Date of Service	
Reason for Use of a **Non-Covered Service**	Comprehensive genomic profiling in a non-covered tumor type to determine treatment options

To be completed by the member or the member's legal guardian:

I am aware that Foundation Medicine will be involved in my care on the date of service listed above. **I am aware that I may be responsible** for any additional costs resulting from my use of a non-covered test, if provided in my benefit plan. **I understand** that Foundation Medicine is generally prohibited from waiving member cost share amounts such as co- payments, deductibles and coinsurance.

Signature of Member, Parent (if the member is under age 18) or Legal Guardian

Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian

Date | Telephone Number

[1] Participating health care providers are required to keep a copy of this completed form on file. Members may request a copy of this completed form from their participating provider.