Test Requisition & Statement of Medical Necessity *continued*

5. Medical Professional Consent *(continued from front)*

As may be required by applicable state laws and regulations, I have informed the patient regarding somatic genomic testing, and the patient has consented for the tests ordered. I understand that GH is relying on the diagnosis or diagnosis code I have provided on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported testing results, and that an incorrect diagnosis or diagnosis code would adversely affect the relevance of the information provided by GH. I understand that I remain free in my medical decisions on how to use the results of any Guardant Health product(s) in my management of this patient. I have obtained the patient's written consent to transmit the health data on this requisition form for the purpose of processing this order and performing all ordered Guardant Health tests. I authorize GH to request and obtain patient tissue samples when the tissue test is ordered and follow-up with the patient to obtain a subsequent blood sample if a Guardant360 Response test is ordered. I understand that PD-L1 immunohistochemical testing is performed using the 22C3 antibody according to manufacturer guidelines. I authorize GH to select the most appropriate test (pursuant to the description in the GH Annual Notice to Physicians: www.GuardantHealth.com/AnnualNotice).

I hereby authorize GH to release test results and relevant medical information to the patient's insurance carrier for reimbursement purposes. I have obtained the patient's consent for GH to submit and, if necessary, appeal claims on the patient's behalf, as well as for GH to receive payment directly from the patient's insurance carrier. I understand that Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. With respect to tests reimbursed by Medicare, Medicaid or other third party payers, I attest that all ordered Guardant Health tests are medically necessary and the results will be used in the management of the patient's condition. I agree to provide a copy of relevant clinical history and medical records in order to support a request from a health plan, at no cost to Guardant Health. I acknowledge that patients who are United States residents may be enrolled in Guardant Access, GH's Financial Assistance Program if eligibile and only upon signing the assignment of benefits form.

I understand that fusions in the FGFR2 gene are only available on the Guardant360 CDx, Guardant360 Response and Guardant360 TissueNext tests.

For Medicare Beneficiaries Only

If Guardant360 CDx is ordered: a Medicare Advance Beneficiary Notice (ABN) must be submitted for any Medicare patient who has previously had a Guardant360 CDx test and has not progressed since the previous test was performed. If Guardant360 is ordered: a Medicare Advance Beneficiary Notice (ABN) must be submitted for any Medicare patient for whom the questions in Section 9 on the previous page are marked in the following manner: NSCLC patients, an ABN is required if (1) question 2 is marked "Yes" or (2) if question 5 is marked "Yes" or (3) if tissue-based CGP from a recent biopsy was feasible but not performed; non-CNS solid tumor patients other than NSCLC, an ABN is required if any question is marked "Yes"; all CNS patients require an ABN. If TissueNext is ordered, a Medicare ABN must be submitted if a CGP test has previously been successfully run on the tissue from the same date of service (i.e. if either question 4 or 5 is marked "Yes" in section 9) or if a TissueNext has previously been performed and the patient has subsequently not progressed since the new tissue specimen was obtained. If Guardant360 Response is ordered and the patient does not meet the medical criteria for coverage, an ABN should be completed. ABN forms that have been pre-populated with Guardant Health's tests/prices can be obtained from Guardant Health Customer Service, Guardant360's product website (www.guardant360.com/ABN) or inside the Guardant360 kit. Completed ABN forms can be sent to Guardant Health with the kit/sample, via fax at 888.974.4258, or emailed to: billing@guardanthealth.com.

Patient Consent for Future Outreach

I am interested in participating in research studies conducted by Guardant Health and, by initialing, I consent to Guardant Health contacting me for future research studies. I understand that initialing does not obligate me to participate.

Patient Initials
X

Patient Assignment of Benefits Form (required)

ASSIGNMENT OF BENEFITS

I hereby assign and convey all applicable health insurance benefits and/or insurance reimbursement, as well as all rights and obligations that I have under my health plan, to Guardant Health for services performed by Guardant Health. I appoint Guardant Health as my authorized representative to:

- File medical claims with my health plan;
- File appeals and grievances with my health plan;
- File appeals or grievances with an external review committee at a state insurance board, independent review organization, Office of Personnel Management, Department of Labor or equivalent agency;
- File a complaint, regarding inaccurate claims processing, appeal processing or pricing to CMS or their agent regarding my Medicare Part C plan;
- Release medical and insurance information necessary to process claims or appeals;
- Obtain medical records related to services provided by Guardant Health when it is required to process a claim or appeal;
- Collect payment of any and all medical benefits and insurance proceeds directly from my health plan (including Medicare and Medicaid);
- Resolve any insurance related matter regarding a service provided by Guardant Health directly with my health plan

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans.
If I receive payment of medical and/or other health benefits on account of services provided by Guardant Health I shall pay Guardant Health the full amount of that payment.

AUTHORIZATION RELEASE

I hereby authorize Guardant Health to

- Obtain my tumor biopsy specimen from the pathology laboratory storing the specimen, and perform diagnostic testing ordered by my physician;
- Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments;
- Process and submit insurance claims generated in the course of examination or treatment; and
- Allow a photocopy of my signature to be used to process insurance claims, payment, grievances or appeals. This authorization will remain in effect until revoked by me in writing.

OUT-OF-NETWORK DISCLOSURE AND PATIENT CONSENT

I understand that Guardant Health services may be designated as an out-of-network service by some insurance plans. As a result, there may be costs associated with these services that are not covered by my insurance plan. I hereby consent for out-of-network services to be provided by Guardant Health.

You may visit www.guardanthealth.com/insurance for a list of insurance plans that consider Guardant Health services as in-network. Guardant Health will provide upon request, the estimated amount that Guardant Health expects to bill for services associated with out-of-network plans.

ERISA AUTHORIZATION

I hereby designate, authorize, and convey to Guardant Health, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, the following:
- The right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action against my health plan that I may have under such insurance policy and/or benefit plan; and
- The right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I understand I can revoke this authorization in writing at any time.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

I hereby consent Guardant Health to evaluate my eligibility for the Guardant Health Financial Assistance Program.

A photocopy of this Authorization shall be as effective and valid as the original.
This form is not an Advanced Beneficiary Notification (ABN).
If you have any questions, please do not hesitate to contact us at 1.855.698.8887 or clientservices@guardanthealth.com.

X

PRINT NAME OF PATIENT

DATE

SIGNATURE OF PATIENT

EMAIL