Dear Patient:

Thank you for your interest in our Patient Financial Assistance Program. Please complete the attached Patient Financial Assistance Application and return it to the correspondence address listed on your invoice.

We will determine your eligibility once we receive your application. Please allow approximately two weeks for your application to be processed and do not make any payments until you receive notification regarding the status of your request.

If you have questions or concerns, please do not hesitate to contact us. Thank you for using Quest Diagnostics. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

Patient Financial Assistance Application

Patient Name: _____ ***Telephone Number:*** _____

Address: _____ ***Patient Date of Birth:*** _____

City, State, Zip: _____

****Invoice Number(s):*** _____ ***Lab Code:*** _____
(*Invoice number is required.)

1. Does the patient have medical insurance coverage? ☐ Yes ☐ No

   If "Yes," please list responsible party information: (Please include a copy of insurance card.)
   ***Insurance Carrier Name*:** _____
   ***Insurance Carrier Address*:** _____
   Insurance Carrier Phone Number: _____
   ***Policyholder Name*:** _____ ***ID#*:** _____

2. Total annual gross household income*: $_____

   **Total household income 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.), Other Income*

3. Number of family members in household supported by above income: _____

4. (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE QUEST DIAGNOSTICS TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFIED AND QUEST DIAGNOSTICS WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

Responsible Party Name (Print): _____

Responsible Party Signature: _____ ***Date:*** _____

<u>For Internal Use Only</u>:

Customer Service Phone Representative Name: _____ ***Date:*** _____

Invoice Number	DOS	Owed Amount	% Approved	Adjusted Amount	Denial Reason

Processor Name:	**Date Received:**	**Date Processed:**
Supervisor Name:	**Supervisor Signature:**	