Dear Patient:

Thank you for your interest in Quest Diagnostics Patient Financial Assistance Program. So that we can determine your eligibility, please complete and sign the attached application form and return it to the correspondence address listed on your invoice.

Once we receive your completed application, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. You will receive notification upon determination of eligibility.

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.

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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:*** ________

For Internal Use Only:

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:**	