Quest®

Knowing feels better

Dear Patient,

Thank you for your interest in our Patient Financial Assistance Program. Please complete the attached application form. This is important in helping us to determine whether you fulfill our requirements. Print out, sign, and return your completed form to the address listed on your bill. Please also include one or more of the following required documents:

- A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub(s)
- A document that shows you qualify for local, state, or federal assistance programs

We'll review your application and documents to see if you meet the program guidelines. It will typically take 2 weeks to process your application. In addition, please do not make any payments until you receive notification on the status of your request. Applying for acceptance into our Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us at questdiagnostics.com/contactus.

Thank you for using Quest. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

Quest Diagnostics Billing Services PO Box 740775 Cincinnati, OH 45274-0775

Patient financial assistance form

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Patient name: Telephone number:

Address: Patient date of birth:

City: State: Zip code:

Bill number(s): Lab code:

Please complete all the information below. The patient's or patient's guardian signature is required. Please make sure to attach the required supporting documents.

1. Does the patient have enough resources to pay for the testing, deductible, and coinsurance?

☐ Yes (If the answer is "Yes," you are responsible for payment.)
☐ No (If the answer is "No," complete the form below.)

2. Is any source other than the patient legally responsible for the patient's medical bills (eg, Medicaid, local welfare agency, guardian, or other insurance program)?

☐ Yes ☐ No If the answer is "Yes," list the below:

Insurance company name:

Address:

Member ID:

Other source:

3. Patient's/legal guardian's monthly household resources:

Salary: $

Social Security: $

Cash/welfare payment: $

Family contribution: $

Income from savings accounts, CDs, etc: $

Other: $

Total: $

4. Number of family members in household:

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I also authorize the release of any and all financial records necessary to verify the above information. 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.

Patient name (Print):

Guardian name (Print):

Responsible party signature:

Date:

For official use only:

Bill number	Amount $	Approved	Denied
Date received:			
PSC representative:			

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