Quest Diagnostics®

QHerit® Expanded Carrier Screen

Supplemental Financial Assistance

Quest Diagnostics offers flexible and easy-to-use financial assistance programs to help cover noninvasive prenatal screening for advanced genetic testing.

Are you eligible for no-fee or reduced fee-testing?

Depending on the number of people in your household and the total household income, you may be eligible to receive testing and **pay no fee ($0) or a reduced fee no greater than $200.** Review the chart below to see if you qualify. If you need additional assistance, Quest offers payment plans with 0% financing.

Find the number of people in your household on the chart. Look at the income across from that number. If your income is less than the amount in the first column, **you may be eligible for no-fee testing.** If your income is between the amounts in the second column, **you may be eligible for reduced-fee testing no greater than $200.**

Example: If you are a family of 4 with $95,000 in income, you may be eligible for testing at no more than $200.

People in household	$0 if HHI* is less than:	Max $200 if HHI* is within:
4	$26,200	$26,200 - $104,800

HHI = Household income.
Based on patient eligibility.*

	Income levels for 48 Contiguous States and the District of Columbia		Income levels for Alaska		Income levels for Hawaii	
People in household	$0 if HHI* is less than:	Max $200 if HHI* is within:	$0 if HHI* is less than:	Max $200 if HHI* is within:	$0 if HHI* is less than:	Max $200 if HHI* is within:
1	$12,760	$12,760 - $51,040	$15,950	$15,950 - $63,800	$14,680	$14,680 - $58,720
2	$17,240	$17,240 - $68,960	$21,550	$21,550 - $86,200	$19,830	$19,830 - $79,320
3	$21,720	$21,720 - $86,880	$27,150	$27,150 - $108,600	$24,980	$24,980 - $99,920
4	$26,200	$26,200 - $104,800	$32,750	$32,750 - $131,000	$30,130	$30,130 - $120,520
5	$30,680	$30,680 - $122,720	$38,350	$38,350 - $153,400	$35,280	$35,280 - $141,120
6	$35,160	$35,160 - $140,640	$43,950	$43,950 - $175,800	$40,430	$40,430 - $161,720
7	$39,640	$39,640 - $158,560	$49,550	$49,550 - $198,200	$45,580	$45,580 - $182,320
8	$44,120	$44,120 - $176,480	$55,150	$55,150 - $220,600	$50,730	$50,730 - $202,920
	For families/households with more than 8 persons, add $4,480 for each additional person.		For families/households with more than 8 persons, add $5,600 for each additional person.		For families/households with more than 8 persons, add $5,150 for each additional person.	

If you are eligible, here's how to apply: After receiving the bill for your test, fill out the form on the back and follow the instructions.

To speak to a Quest billing specialist, call **1.866.697.8378** and reference QHerit Expanded Carrier Screen **94372(X).**

* The financial criteria in the first column above is based upon the US Department of Health and Human Services Guidelines for 2020. The guidelines are updated annually and are available at the HHS website (https://ASPE.HHS.gov/Poverty-Guidelines). Quest Diagnostics reserves the right to modify or terminate this program at any time.

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Apply for supplemental financial assistance for prenatal testing

Fill in the application below and provide **one (1)** of the following pieces of documentation:

- 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 proof source indicating that you are eligible for local, state, or federal assistance programs

Mail the application and 1 piece of documentation to the address listed on your Quest bill.

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately 2 weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request. Applying for acceptance into our Financial Assistance Program does not guarantee reduced charges.

Patient name: ..... **Telephone number:** .....

Address: ..... **Patient's date of birth:** .....

City: ..... **State:** ..... **Zip code:** .....

Invoice number(s): ..... **Lab code:** .....

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

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?

☐ **Yes** If answer is "Yes," you are financially responsible for payment.

☐ **No** If answer is "No," complete 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 answer is "Yes," list:

Insurance company name: .....

Address: .....

Member I.D.: ..... Other source: .....

3. Patient/legal guardian's monthly 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 and belief. 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: _____ **PCS rep:** _____ **Supervisor (signature):** _____