Dear Patient,

Thank you for your interest in our Patient Financial Assistance Program. So that we can determine your eligibility, please complete the attached application form and return it to the correspondence address listed on your invoice, along with one or more of the required documents listed below:

- 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.

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two 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.

If you have any additional 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 Form

Patient Name: _____ **Telephone Number:** _____
Address: _____ **Patient 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 (**e.g**., 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 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:			
PCS Rep:			