## Client Service and/or Financial Assistance Application

*Client Name:* ______________________________ *Telephone Number:* ____________________

*Address:* ______________________________ *Client Date of Birth:* ____________________

*City, State Zip:* ______________________________

1. Does the Client 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. List all services you are applying for. 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 QUALITY, 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 ORDER THE TESTING.

*Responsible Party Name (Print):* ______________________________

*Responsible Party Signature:* ______________________________ *Date:* ____________

*For Internal Use Only:*

*Customer Service Phone Representative Name:* ______________________________ *Date:* ____________

### FOR OFFICE USE ONLY

| Invoice Number | DOS | Owed Amount | % Approved | Adjusted Amount | Denial Reason |
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| Intake Officer Name: | Date Received: | Date Processed: |
|---|---|---|
| Intake Officer Signature: | Executive Signature: | |