Patient financial assistance form

Quest
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Patient name: John A. Miller
Telephone number: (555) 482-3791
Address: 2145 Maplewood Drive
Patient date of birth: 06/14/1985
City: Denver
State: CO
Zip code: 80204
Bill number(s): 87451293
Lab code: QD-2024-5678

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.)
[X] 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)?

[X] Yes [ ] No If the answer is "Yes," list the below:

Insurance company name: HealthFirst of Colorado
Address: 3500 Blake Street, Denver, CO 80205
Member ID: HF-98347291
Other source: Employer-sponsored health plan

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

Salary:	$ 2,800
Social Security:	$ 0
Cash/welfare payment:	$ 250
Family contribution:	$ 200
Income from savings accounts, CDs, etc:	$ 50
Other:	$ 0
Total:	$ 3,300

4. Number of family members in household: 3

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): John A. Miller
Guardian name (Print): N/A
Responsible party signature: John A. Miller
Date: 10/13/2025

For official use only:

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

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