Quest
Knowing feels better

Patient financial assistance form

Patient name: Emily R. Carter
Telephone number: (555) 123-9876
Address: 789 Pinecrest Lane
Patient date of birth: 03/22/1990
City: Madison
State: WI
Zip code: 53703
Bill number(s): 56239841
Lab code: QD-2025-1122

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: Midwest Health Partners
Address: 1010 University Ave, Madison, WI 53706
Member ID: MHP-44556677
Other source: State Medicaid

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

Salary:	$ 3,100
Social Security:	$ 200
Cash/welfare payment:	$ 0
Family contribution:	$ 150
Income from savings accounts, CDs, etc:	$ 75
Other:	$ 25
Total:	$ 3,550

4. Number of family members in household: 4

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): Emily R. Carter
Guardian name (Print): Michael Carter
Responsible party signature: Emily R. Carter
Date: 10/15/2025

For official use only:

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

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