Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

424 South 56th Street, Suite 100
Phoenix, Arizona 85034
(P) 602.685.5000 | (F) 480.565.3962

Patient Financial Assistance Application

Patient Name: **Telephone Number:**
Address: **Date of Birth**:
City: **State:** **ZIP Code:**

1. Does the patient have medical insurance coverage? ☑ Yes ☐ No

If "Yes" please list responsible party information: (If possible, include a copy of insurance card)

Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone Number: _____
Policyholder Name: _____
Policyholder ID Number: _____

2. * Total annual gross household income: $_____

***** Total household income includes the following for all household members: Gross Salary, Unemployment Compensation, Disability, Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Other Income.

3. Number of family member in household supported by the above income: _____

4. (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

_____
_____
_____

I hereby acknowledge that the above information is true and correct. I authorize Sonora Quest Laboratories 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 qualify, I will be notified and Sonora Quest Laboratories will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Responsible Party (Print): _____

Responsible Signature: _____ ***Date:*** _____

For Official Use only:

Billing Representative Information
Employee Name/Department Name:
Phone: 602-685-5051

Bill Number	**Amount $**	**Approved**	**Denied**
Date Received:			
Supervisor (signature):			