



Submission Date _____

Preliminary Application Form

Please complete this form and submit it with all other supporting materials. Applicants will be contacted once the form is reviewed. Quest Kids will make every attempt to provide assistance.

Child's Full Name _____ Date of Birth _____

Parent's Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

Insurance Type _____

Insurance Provider Eligibility & Benefits Phone Number _____

NOTE: The insurance information below can be copied and faxed to 407.218.4303.

Subscriber Name _____ Date of Birth _____

Member ID # _____ Group # _____

Diagnosis _____ Date of Diagnosis _____

Diagnosing Doctor _____

Behaviors/Areas of Concern _____

Days/Times Preferred _____

Mail or fax completed application to: Quest Kids
500 E. Colonial Dr.
Orlando, FL 32803
407.218.4303