Submission Date _____

Preliminary Application Form

Please complete this form and submit it with the following supporting documentation: 1) front and back of insurance card; 2) letterhead diagnostic and ABA referral; and 3) comprehensive diagnostic evaluation. 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

FOR OFFICE USE ONLY:

Primary Therapist _____ Location _____