

Statement of Treatment



HEALTHWELL
FOUNDATION®

SECTION 1: PRESCRIBING PROVIDER INFORMATION

Prescribing provider: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____

Email: _____

Who is the primary contact for this application? (office staff, social worker)

first and last name *preferred*; first name and *at least last name initial required*

Telephone: _____ Fax: _____

SECTION 2: PATIENT INFORMATION

My patient, _____, is being treated for _____
Provide Diagnosis -- ICD-9 codes will be REJECTED --

Date of Birth: _____ Social Security Number: _____

SECTION 3: MEDICATION(S) *List medications prescribed for the diagnosis indicated above*

Drug Name: _____

Drug Name: _____

Drug Name: _____

I understand that the HealthWell Foundation® offers assistance to eligible patients for treatments/products expressly covered by the foundation. While the foundation will make every effort to grant assistance when needed, the program is limited by available resources and may be discontinued or changed at any time. I further certify that the use of the treatment/product described is medically necessary and I will be supervising the patient's treatment accordingly.

PLEASE NOTE: A patient is free to change his/her physician, pharmacy, or the type of medication he/she is taking at any time, and this will not affect his/her enrollment.

X

Physician, Physician's Assistant or Nurse Practitioner's Original Signature
(STAMPED SIGNATURES NOT VALID)

Date

When health insurance is not enough.™